

BP

DHMH - 17  
(VR 115 ME (5))  
15M7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG NO. 8 0 2 3 5 4 0	
1. DECEASED NAME (TYPE OR PRINT) <b>Mary E. Amend</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>9 21 19 80</b>		2b. HOUR <b>7:30 PM</b>			
3. SEX <b>F</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>25</b> YEAR <b>99</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>80</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	2c. DATE PRONOUNCED DEAD <b>9 22 19 80</b>		2d. HOUR <b>4:30 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.					
10. CITY OR TOWN OF DEATH <b>Edgewood Md.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>820 Fisherman Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Edgewood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>820 Fisherman Lane</b>			
14. FATHER'S NAME FIRST <b>HORNEY</b> MIDDLE <b></b> LAST <b></b>				15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b>Edgewood, Md.</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-07-1971</b> <b>213-74-5781</b>		17. INFORMANT <b>Mrs. Ann M. Devoe - 1966 Sidnee Dr. 21040</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>4140</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Willard P. Amoss</b>				TITLE (SPECIFY) <b>Asst Dep</b>		MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (TYPE OR PRINT) <b>Willard P. Amoss</b>				ADDRESS <b>2404 Pleasantville Rd, Fallston Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-25-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem</b>				23d. LOCATION CITY OR TOWN <b>Balto. Md.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd.-21206</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>SEP 24 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

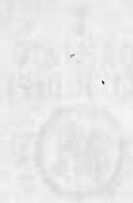
1. DECEASED NAME (Type or Print) <b>Buster W. Bailey</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>9</b> Day <b>5</b> Year <b>1980</b>			2b. HOUR <b>12</b> M <b>PM</b>		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>3/23/1915</b>	6. AGE (in years last birthday) <b>65</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>9</b> Day <b>6</b> Year <b>1980</b>		2d. HOUR <b>12</b> M <b>PM</b>
7a. BIRTHPLACE (State or foreign country) <b>Va</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>HARFORD</b> Md		
10. CITY OR TOWN OF DEATH <b>Aberdeen</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>450 Holly Dr.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Discharge</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution; admission) STATE <b>Md</b>			13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>Aberdeen</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>450 Holly Dr.</b>	
14. FATHER'S NAME First <b>James</b> Middle <b>Bailey</b> Last <b>Bailey</b>			15. MOTHER'S MAIDEN NAME First <b>Molly</b> Middle <b>Profit</b> Last <b>Profit</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>445-18-1532</b>		17. INFORMANT ADDRESS <b>Buster W. Bailey Jr. Casselberry Flg. 32707</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b>								
DUE TO, OR AS A CONSEQUENCE OF <b>Pneumoconiosis</b>								
(b) <b>Attack - lung disease</b>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <b>19</b> A.M. <b>P.M.</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Luis E. Renjel</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>9-6-80</b>		
EXAMINER'S NAME (Type) <b>Luis E. RENJEL</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>9/10/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Graveside Cemetery</b>		23d. LOCATION (City or Town) <b>Boysenville Toxville Co. Va</b>		(County) (State)
24. FUNERAL DIRECTOR <b>Terrell Funeral Home - Aberdeen - Md 21001</b>				25a. RECD BY REGISTRAR <b>SEP 15 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick Kelley</b>		

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "FMT-2000".

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.



COPIES OF THE REPORT

REPORT OF THE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 23542			
1 - FOR STATE REGISTRAR							
1 DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> John <sup>MIDDLE</sup> Rush <sup>LAST</sup> Baldwin, Jr.				2a DATE OF DEATH <sup>MONTH</sup> 9 <sup>DAY</sup> 28 <sup>YEAR</sup> 80 <sup>2b HOUR</sup> 6:27 P.M.			
3 SEX MALE		4 RACE White		5 DATE OF BIRTH <sup>MONTH</sup> 9 <sup>DAY</sup> 14 <sup>YEAR</sup> 1892		6 AGE (IN YEARS LAST BIRTHDAY) 88 <sup>YRS</sup> <sup>IF UNDER 1 YEAR</sup> MONTHS <sup>IF UNDER 24 HRS</sup> DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH FALLSTON Harbor Co., MD	
10 CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b KIND OF BUSINESS OR INDUSTRY Agriculture	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a STATE Maryland		13b COUNTY Harbor Co.		13c CITY OR TOWN Bel Air		13e STREET ADDRESS 135 Williams Street	
14 FATHER'S NAME <sup>FIRST</sup> John <sup>MIDDLE</sup> Rush <sup>LAST</sup> Baldwin				15 MOTHER'S MAIDEN NAME <sup>FIRST</sup> CORA <sup>MIDDLE</sup> <sup>LAST</sup> Baldwin			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 213-38-8720		17 INFORMANT (NAME) 1-717-456-5673 ADDRESS R.D.#1 Mr. J. Rush Baldwin, III DELTA, PENNSYLVANIA 17314			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 436 - Blaternal Cerebrovascular Accident							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b SIGNATURE Winston Hugh Williams MD				DEGREE		22c DATE SIGNED 9/28/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Winston Hugh Williams MD				22e ADDRESS Fallston General Hospital			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Sept. 30, 1980		23c NAME OF CEMETERY OR CREMATORY Rock Spring Episc. Ch. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Forest Hill, Harbor Co., Maryland 21050	
24 FUNERAL DIRECTOR Joseph William Foster				25a DATE REC'D. BY REGISTRAR OCT 1 1980		25b REGISTRAR'S SIGNATURE [Signature]	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED, WITH PAGES 4 AND 5, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH: 17  
(VR A15 AE (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST JOSEPH		MIDDLE MELVIN		LAST BALL III		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 19		DAY 9		YEAR 1980		2b. HOUR 6 PM	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 2 8 73		6. AGE (IN YEARS) LAST BIRTHDAY 7 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 28 1980		2d. HOUR 6 PM		2e. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.		10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dependent		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1903 Harbinger Trail		14. FATHER'S NAME FIRST MIDDLE LAST Joseph M. Ball, Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia E. Kirschner		16. SOCIAL SECURITY NO. None		17. INFORMANT 1903 Harbinger Trail Joseph M. Ball, Jr. Edgewood, MD 21040	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7469 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		Cardiac Arrest		Congenital Heart Disease - Epsteins Syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE Willard P. Amoss		TIME (SPECIFY) M.D. Asst. Dir.		MEDICAL EXAMINER		DATE SIGNED 9/29/80											
EXAMINER'S NAME (TYPE OR PRINT) Willard P. Amoss		ADDRESS 2404 Pleasantville Rd, Fallston Md 21047															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/1/80		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland											
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		ADDRESS 7922 Wise Avenue, Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR OCT 1 1980		25b. REGISTRAR'S SIGNATURE R. H. H. H.											



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(M)

JOSEPH M. BROWN  
The Council of the City of New York  
1900

JOSEPH M. BROWN  
The Council of the City of New York  
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JOSEPH M. BROWN  
The Council of the City of New York  
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JOSEPH M. BROWN  
The Council of the City of New York  
1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 3 5 4 4	
1 - FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Bell			2a DATE OF DEATH MONTH DAY YEAR 9 24 80		2b HOUR 3-15am
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR April 15, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10 CITY OR TOWN OF DEATH Harve-De-Grace	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeping		12b KIND OF BUSINESS OR INDUSTRY B.N.J.C.
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Cecil Port Deposit			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS Race Street
14 FATHER'S NAME John Williams		15 MOTHER'S MAIDEN NAME Mary Williams			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b SOCIAL SECURITY NO 217-20-4157		17 INFORMANT ADDRESS Lucille Griffin, Port Deposit, Maryland.	
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.					
22b SIGNATURE Leticia S. Galvez		DEGREE M.D.		22c DATE SIGNED 9/24/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) LETICIA S. GALVEZ, M.D.		22e ADDRESS 625 S. UNION AVE. HARVE DE GRACE			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Sept. 27, 1980		23c NAME OF CEMETERY OR CREMATORY Baptist Church Em.	
23d LOCATION CITY OR TOWN COUNTY STATE Port Deposit Cecil Maryland					
24 FUNERAL DIRECTOR NAME Lee A. Patterson & Son, Perryville, Maryland.		25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 1 1980			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 23545

REG. NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) MARION Elsworth Blackburn			2a DATE OF DEATH MONTH DAY YEAR Sept. 14 1980			2b HOUR 7:10 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 16 11		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD	
10 CITY OR TOWN OF DEATH Havre De Grace		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b KIND OF BUSINESS OR INDUSTRY Vet. Adm.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.		13b COUNTY Cecil		13c CITY OR TOWN Perryville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Edward Cleveland Blackburn		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith May Wilson		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No		16b SOCIAL SECURITY NO. 218-26-4630	
17 INFORMANT ADDRESS							

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Carcinoma colon (post surgical)</u>			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	

21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (this hospital) attended the deceased from 9-2 1980, to 9-14 1980, that (I) (we) last saw the deceased alive on 9-14 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE <u>Leticia S. Galvez</u>		DEGREE M.D.		22c DATE SIGNED 9-15-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) LETICIA S. GALVEZ, M.D.		22e ADDRESS 625 S. UNION AVE HAVRE DE GRACE, MD.			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b DATE 9/15/80		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a DATE REC'D. BY REGISTRAR SEP 19 1980	
				25b REGISTRAR'S SIGNATURE <u>Leticia S. Galvez</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1894

002 01932

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 4 6

FOR  
STATE  
REGISTRAR

REG. NO.

(M)

1. DECEASED NAME (TYPE OR PRINT) Annabelle Catherine Blackiston		2a. DATE OF DEATH MONTH DAY YEAR 09 - 08 - 80		2b. HOUR 11:15 A	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 08 22 99		6. AGE (IN YEARS LAST BIRTHDAY) 81 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford, MD	
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker
13a. STATE Md.		13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Hornberger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Hamilton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-54-0380		17. INFORMANT (Daughter) 838-4082 ADDRESS 128 Courtland Place Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) } melastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF } (c) } ( Cause undetermined )					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION 9-4-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal mass - inf. flowing Ca		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Laura Lane		DEGREE MD		22c. DATE SIGNED 8th Sept 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rafiq Patel		22e. ADDRESS Edgewood Professional Bldg. Rd. 21040			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 10, 1980		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014		23e. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014			
24. FUNERAL DIRECTOR NAME ADDRESS Southern William Foster Baltimore, Md.		25a. DECEASED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE notary McCreedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



8

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME 5)  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 23547			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE ANNA BUCKLEY										MONTH DAY YEAR 19		M	
3 SEX FEMALE		4 RACE CAUC.		5 DATE OF BIRTH (MONTH DAY YEAR) 8-7-1912		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 9-15-1980		2d. HOUR 357 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10 CITY OR TOWN OF DEATH Fallston				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE MARYLAND				13b. COUNTY HARFORD		13c. CITY OR TOWN FOREST HILL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1620 REBECCA CT. - Apt. D			
14. FATHER'S NAME FIRST MIDDLE LAST HENRY M. KRAIN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE KRAINING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215-50-7450		17. INFORMANT (Husband) 838-2867 ADDRESS MR. FRANK T. BUCKLEY 1620 REBECCA ST. - Apt. D Forest Hill Md. 21050							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Metastatic Carcinoma of Pancreas</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Willard P Amoss</u>				TITLE (SPECIFY) <u>Asst Rep</u>				DATE SIGNED <u>9/16/80</u>				MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <u>Willard R Amoss</u>				ADDRESS <u>2404 Pleasantville Rd, Fallston Md</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>Sept. 18, 1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bel Air Harford Co Maryland 21014</u>			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>				ADDRESS <u>W Broadway &amp; Williams St Bel Air, Maryland 21014</u>				25a. DATE <u>SEP 18 1980</u> BY REGISTRAR <u>John J. Kelly</u> 25b. REGISTRAR'S SIGNATURE					



2011-5-3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>William Hepburn Clark</b>						2a. DATE OF DEATH Month <b>9</b> Day <b>9</b> Year <b>80</b>				2b. HOUR <b>9<sup>01</sup> PM</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>07-28-17</b>		6. AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Hartford</b>				
1d. CITY OR TOWN OF DEATH <b>Fallston</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fallston General Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Penn Central RR</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Conductor</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Hartford</b>		13c. CITY OR TOWN <b>Joppa</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>547 Joppa Farm Rd.</b>	
14. FATHER'S NAME First <b>Orval</b> Middle <b>Welker</b> Last <b>Clark</b>				15. MOTHER'S MAIDEN NAME First <b>Frances</b> Middle <b>Edna</b> Last <b>Phleegor</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-01-1848</b>		17. INFORMANT <b>547 Joppa Farm Rd.</b> <b>Joppa, Md. 21085</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4149 Caroline Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Ischemic Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Joseph Reinhardt</b>										22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS <b>2003 Rock Spring Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-12-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore City Md.</b>			
24. FUNERAL DIRECTOR <b>Howard K. McComas III</b>				ADDRESS <b>Box 157 Cokesbury</b>		25a. RECD BY REGISTRAR <b>SEP 15 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Kathy McComas</b>		

SEP 18 1960

FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) James Victor Abraham Collins			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 9 - 29 1980			2b. HOUR 11 A.M.			
3. SEX Male	4. RACE Cau.	5. DATE OF BIRTH 9/3/1909	6. AGE (In years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 9 29 1980			2d. HOUR 9 P.M.
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md			
10. CITY OR TOWN OF DEATH Forest Hill		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1807 Bernadette Ct.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Chief		12b. KIND OF BUSINESS OR INDUSTRY Resorts			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1632 Dulaney Drive
14. FATHER'S NAME First Middle Last James Victor Collins			15. MOTHER'S MAIDEN NAME First Middle Last Albina LaParme						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II 115-10-0775		17. INFORMANT Simonne Charron Collins			ADDRESS same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Atherosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Willard P. Amoss			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 9/29/80	
EXAMINER'S NAME (Type) Willard P. Amoss						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county) 2404 Pleasantville Rd. Fallston, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 3, 1980		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cem.		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md.			
24. FUNERAL DIRECTOR M. G. Kurtz III				ADDRESS Jarrettsville, Md.		25a. RECEIVED BY REGISTRAR DATE OCT 3 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

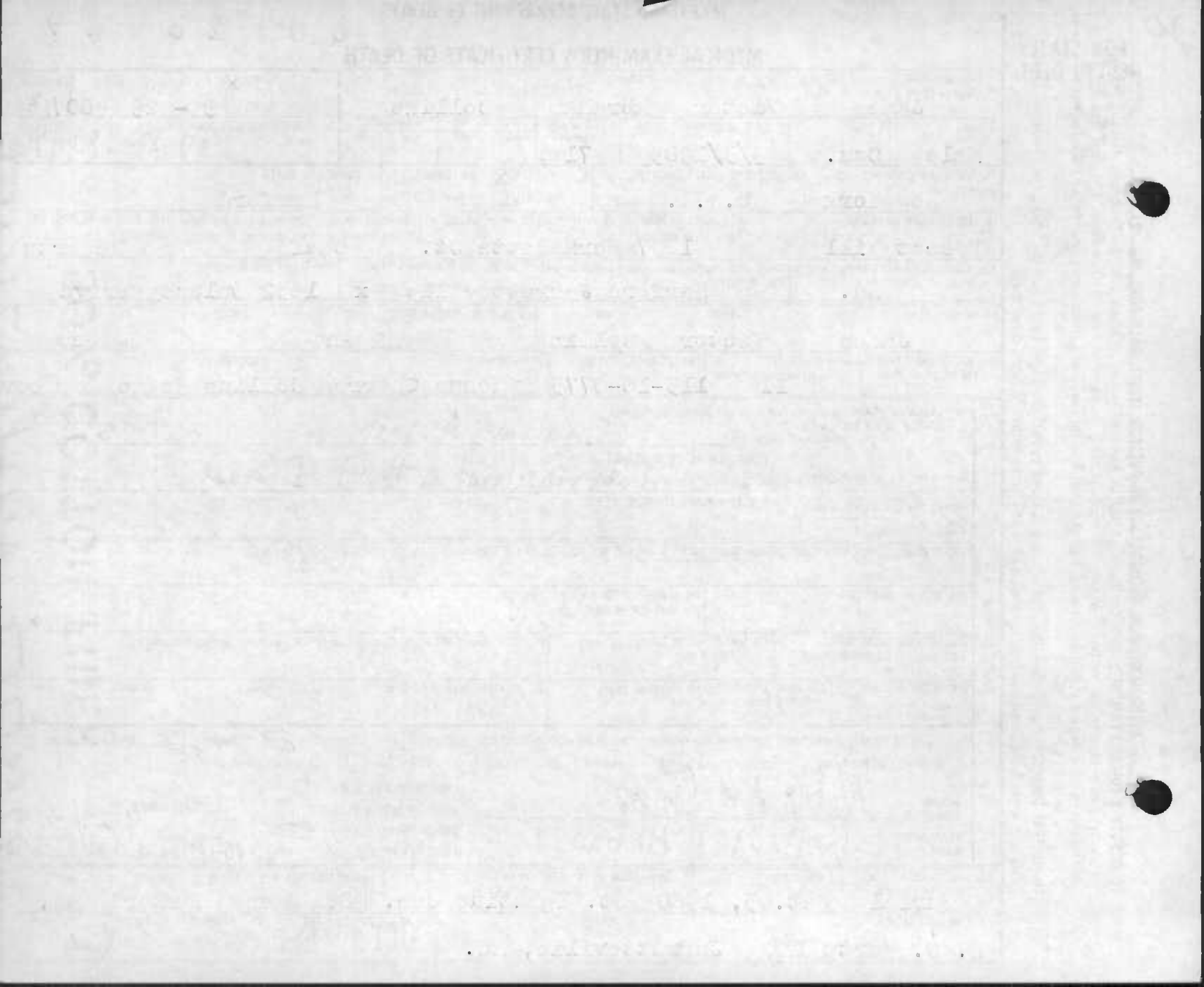
MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 2 and 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Verdic ALICE Combs</b>		2a. DATE KNOWN OF DEATH MONTH <b>9</b> DAY <b>27</b> YEAR <b>1980</b>		7b. HOUR <b>6:45</b> AM	
3. SEX <b>F</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>12</b> YEAR <b>1995</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	7c. DATE PRONOUNCED DEAD MONTH <b>9</b> DAY <b>27</b> YEAR <b>1980</b>	7d. HOUR <b>9:45</b> PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD.	
10. CITY OR TOWN OF DEATH <b>Street</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1114 Poplar Grove Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>Harford</b>		13c. STREET ADDRESS <b>1114 Poplar Grove Road</b>	
14. FATHER'S NAME FIRST <b>Henderson</b> MIDDLE <b>--</b> LAST <b>Joiner</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Ann</b> LAST <b>Crouse</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-16-8598</b>		17. INFORMANT ADDRESS <b>Lewis H. Combs, Darlington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Willard P. Amos</b>		TITLE (SPECIFY) <b>Asst. Dep.</b>		DATE SIGNED <b>9/28/80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Willard P. Amos</b>		ADDRESS <b>2404 Pleasantville Rd. Fallston Md 21047</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 30, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury U.M. Cemetery Abingdon</b>	
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III</b>		ADDRESS <b>Abingdon, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 30 1980</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/791- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 5 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) John Paul Cook Sr.			2a. DATE OF DEATH MONTH DAY YEAR September 24, 1980			2b. HOUR 10 <sup>30</sup> AM				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 26, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7 UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD				
10 CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comp. Programmer		12b. KIND OF BUSINESS OR INDUSTRY US-govt. Ret.		
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2412 Hanson Road	
14. FATHER'S NAME FIRST MIDDLE LAST John J. Cook			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie -- Willick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO 219-07-2463		17 INFORMANT ADDRESS Mrs. Alma Cook, Edgewood, Md.					
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1713 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pleural Effusion (L) + Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pleomorphic Lipoma-Sarcoma (R) High</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Charles J. Foley Jr. M.D.						22c. DATE SIGNED 9/24/80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. FOLEY JR M.D.		
22e. ADDRESS Havre de Grace, Md. 21078						22f. MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 27, 1980		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.			
24 FUNERAL DIRECTOR NAME Howard K. McComas III, ADDRESS Abingdon, Md.						25a. DATE REC'D. BY REGISTRAR SEP 26 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION



X

James J. Folger, Jr.

James J. Folger, Jr. 1895

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. IF YOU ARE THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WALTER EARLE CRESWELL</b>		2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>9 16 1980</b>		2b. HOUR <b>11<sup>00</sup> PM</b>	
3. SEX <b>M</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 28, 1921</b>	6. AGE IN YEARS (LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN <b>58</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 17 1980</b>	7d. HOUR <b>1<sup>00</sup> PM</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		7. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.	
10. CITY OR TOWN OF DEATH <b>JOPPA</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>625 Magnolia Rd. Hvy. Equip. Opr. US-govt. Ret.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Joppa</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William -- Creswell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dora -- Dolan</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWII</b>	
16b. SOCIAL SECURITY NO. <b>215-14-0590</b>		17. INFORMANT ADDRESS <b>Mrs. Florence Creswell, Joppa, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Arterio sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Willard R. Amos</b>		TITLE (SPECIFY) <b>Asst. Dir.</b>		DATE SIGNED <b>9/17/80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Willard R. Amos</b>		ADDRESS <b>2404 Pleasantville Rd. Fiddon Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 19, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>	
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III</b>		ADDRESS <b>Abingdon, Md.</b>		25a. DATE RECD. BY REGISTRAR <b>SEP 18 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>John H. ...</b>					

BP

0321 81032

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VS A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST Joseph		MIDDLE Henry		LAST Crone		2a. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> 9 / 1 / 1980		2b. HOUR 10:54 P.M.	
3 SEX M	4 RACE Cauc	5 DATE OF BIRTH MONTH DAY YEAR 6 / 18 / 1920		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 19		2d. HOUR M			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.							
10 CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock Clerk - Cloverland Dairy		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY Hartford		13c. CITY OR TOWN Baldwin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14104 Baldwin Mill Rd.					
14. FATHER'S NAME FIRST MIDDLE LAST Josh Crone				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Porter				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 212-03-3111				17. INFORMANT Mrs. Betty Murphy 14104 Baldwin Mill Rd., Baldwin, MD 21013									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) Arteriosclerotic Heart Disease (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Willard P. Amoss				TITLE (SPECIFY) M.D. Asst. Dir.				MEDICAL EXAMINER 2404 Pleasantville Rd. Fallston Md.				DATE SIGNED 9/2/80	
EXAMINER'S NAME (TYPE OR PRINT) Willard P. Amoss				ADDRESS 2404 Pleasantville Rd. Fallston Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/5/80		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, P.A. 8728 Liberty Rd., Randallstown, MD 21133										25a. DATE REC'D. BY REGISTRAR SEP 3 1980		25b. REGISTRAR'S SIGNATURE Loring Byers	

Page 1 of 1

1-1-1

(M)

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FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month Day Year	2b. HOUR 10:30 AM
NEVILLE MORRIS CULLUM						9 4 1980				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR 4:00 PM
Male	White	3 August 1930	50 YRS.					9 4 1980		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford Md.	
Maryland			USA							
10. CITY OR TOWN OF DEATH Aberdeen			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 11 Grant Street			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Civilian Gunner			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11 Grant Street
Maryland			Harford			Aberdeen				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Frank Elwood Cullum			Catherine S. Morris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
Yes			Korea			212-26-6338 Fay Cullum, 11 Grant St., Aberdeen, Md. 21001				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Louis E Renjel</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 9-4-80				
EXAMINER'S NAME (Type) <u>LOUIS E RENJEL MD</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 9 Sept. 1980		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens			23d. LOCATION (City or Town) (County) (State) Bel Air Harford Maryland		
24. FUNERAL DIRECTOR Tarring Funeral Home, P.A., Aberdeen, Md. 21001						25. BY REGISTRAR <u>10/10/80</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





MEMORANDUM FOR THE RECORD

TO : Mr. Tolson  
FROM : Mr. E. A. Tamm  
SUBJECT: [Illegible]  
DATE: [Illegible]  
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]



Very truly yours,  
[Illegible Signature]  
[Illegible Title]  
[Illegible Date]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>NORA MAY CUTLIP</b>			2a DATE OF DEATH (MONTH) DAY YEAR <b>SEP 9-22-80</b>		2b HOUR <b>12:50 P.M.</b>
3 SEX <b>FEMALE</b>	4 RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>01 24 93</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS	7 IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD	
10 CITY OR TOWN OF DEATH <b>FALLSTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston Gen Hosp.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Production</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Shoe Manufacture</b>
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b COUNTY <b>Harford Co.</b>	13c CITY OR TOWN <b>Whiteford</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Eddie Kinnison</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Rock</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO <b>203-24-923</b>		17 INFORMANT (Print) <b>836-1565</b> ADDRESS <b>Mrs. Ruth V. Doss 1509 Ridge Road Whiteford, Maryland 21160</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable Septic.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Urinary Tract Infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>4 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cancer of Colon to multiple metastasis</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the hospital) attended the deceased from <b>9/20</b> 19 <b>80</b> to <b>9/22</b> 19 <b>80</b> that (I) (we) lost saw the deceased alive on <b>9/22</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b SIGNATURE <b>Randall C. Cronin, Jr.</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>9/22/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Randall C. Cronin, Jr.</b>		22e ADDRESS <b>721 Wheeler School Rd. Whiteford, Md. 21160</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>Sept. 24 1980</b>	23c NAME OF CEMETERY OR CREMATORY <b>Bell Air Memorial Gardens</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Bell Air Harford Co. Maryland 21014</b>	
24 FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>Widow's Way &amp; Williams Sts</b> <b>Baltimore Md</b>		25a DATE REC'D. BY REGISTRAR <b>SEP 24 1980</b>		25b REGISTRAR'S SIGNATURE <b>Jeffrey M. [Signature]</b>	

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

98-25-9

73

11/10/50

15

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 5 6

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) PEARL A. CUTTERIDGE			2a DATE OF DEATH MONTH DAY YEAR 9 - 19 - 80			2b HOUR 3:55P M	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 9 - 10 - 95		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD	
10 CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS N.H.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD				13b COUNTY HARFORD		13c CITY OR TOWN HAVRE DE GRACE	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM MOSSMAN				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERSA DE WEESE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 313 055 267		17 INFORMANT ADDRESS 733 FALCONER HAMMOND JOPPATOWNE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Brain Syndrome</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>J. T. Lee</u>				DEGREE M.D.		22c DATE SIGNED 9/24/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. T. LEE				22e ADDRESS Union Med Clinic Harford Gt			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b DATE 9/20/80		23c NAME OF CEMETERY OR CREMATORY OAK HILL CEM		23d LOCATION CITY OR TOWN COUNTY STATE EVANSVILLE MD	
24 FUNERAL DIRECTOR NAME J. G. CONNELLY				ADDRESS 300 MACE		25 DATE RECEIVED BY HEALTH DEPARTMENT SEP 24 1980	

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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 FOR  
1 - STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 3 5 5 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Josephine Mary Di Mauro			2a. DATE OF DEATH MONTH DAY YEAR September 2 1980		2b. HOUR 12 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 9 27 1900		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS	7 UNDER 1 YEAR MONTHS DAYS 8 UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10 CITY OR TOWN OF DEATH Harford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mens Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY SAME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Harford	13c. CITY OR TOWN Harford	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 718 Erie Street	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Marconi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Domenica Anagnelli			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 16 4939		17 INFORMANT ADDRESS MARIO DIMAURO, 40 21 CHAPEL ROAD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2500 Septicemia, CVA DUE TO, OR AS A CONSEQUENCE OF (b) H.A.S.C.D. (c) Diabetic mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 8-30 to 9-2, 1980, that (1) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE John D. Yun		DEGREE		22c. DATE SIGNED 9/2/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Yun		22e. ADDRESS Harford, Md.		22f. PHYSICIAN'S NAME (TYPE OR PRINT) Harford, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9/5/1980	23c. NAME OF CEMETERY OR CREMATORY MT ERIN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD, MD.	
24. FUNERAL DIRECTOR NAME Remington & Son, Howard, Md.		24b. ADDRESS SEP 4 1980		24c. BY WHOM [Signature]	





**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTER

1. DECEASED NAME (TYPE OR PRINT) <b>Carl Ray Evans</b>			2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 9 6 19 80			2b. HOUR M 11:30 A.M.		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 25, 1962</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>17 YRS.</b>	IF UNDER 1 YR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD 9 6 19 80		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mississippi</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Aberdeen</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Railroad Tracks-Belair Crossing</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>E-1</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>
13a. STATE <b>Mississippi</b>		13b. COUNTY <b>Jasper Co.</b>		13c. CITY OR TOWN <b>Pettal</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>203 E. Hillcrest Loop</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lenford - Evans</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty - Nix</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Active Duty</b>		17. INFORMANT ADDRESS <b>Lenford Evans (Father) same as #13.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Multiple Injuries**

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 9 6 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject found on Railroad Tracks</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>railroad tracks</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Belair Crossing, Aberdeen, Harford, Maryland</b>	

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion  
 death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒.

ACTUAL SIGNATURE Margarita A. Korell M.D. TITLE (SPECIFY) **Assistant** MEDICAL EXAMINER DATE SIGNED **9-7-80**

EXAMINER'S NAME (TYPE OR PRINT) **Margarita A. Korell, M.D.** ADDRESS **111 Penn Street**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept/18/80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Hill Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bay Springs, Jasper Co., Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Chambers Funeral Home Riverdale, Maryland</b>			25a. DATE REC'D BY REGISTRAR <b>SEP 22 1980</b> 25b. REGISTRAR'S SIGNATURE <u>Forney McBrady</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, TO EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

269532

6

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 5 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) WALTER EMIL FABIAN			2a DATE OF DEATH MONTH DAY YEAR 9 26 80			2b HOUR 9.00 A M				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 05 15 1918		6 AGE (IN YEARS LAST BIRTHDAY) 62		7 UNDER 1 YEAR MONTHS DAYS YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD				
10 CITY OR TOWN OF DEATH FALLSTON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b KIND OF BUSINESS OR INDUSTRY Beth. Steel		
13a STATE Maryland			13b COUNTY Harford		13c CITY OR TOWN Belair		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Martin Fabian			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Fleischer			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II			16b SOCIAL SECURITY NO 172-10-4748	
17 INFORMANT ADDRESS Georgia L. Rogalski 301 Wakefield Dr			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure 4912 DUE TO, OR AS A CONSEQUENCE OF Emphysema, chronic (b) Since 1960. DUE TO, OR AS A CONSEQUENCE OF Bronchitis. (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 9-25 19 80, to 9-26 19 80, that (I) (we) lost saw the deceased alive on 9-25 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b SIGNATURE B. PAREKH MD.			DEGREE MD			22c DATE SIGNED 9-26-80.			22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD.			22f ADDRESS 1131 Belair Rd. Balto MD 21014.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 9/29/80		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d LOCATION CITY OR TOWN COUNTY STATE Overlea Baltimore Md.			
24 FUNERAL DIRECTOR NAME Lassahn Funeral Home			24b ADDRESS 7401 Belair Road			25a DATE REC'D. BY REGISTRAR SEP 29 1980		25b REGISTRAR'S SIGNATURE [Signature]		

DHMH-16 25M  
(VRA 15, 4) 1/79



Ward - English

Date

02 15 1918

02

HARRARD

Administrative

Respiratory Failure

Chronic

Respiratory Failure

Chronic

Chronic

Chronic

Respiratory Failure

Respiratory Failure

Chronic

Respiratory Failure

X

02 15 1918

02

02

Ref

X

MD

02 15 1918

B. PAREKH MD

General

02 15 1918

02

02

02 15 1918

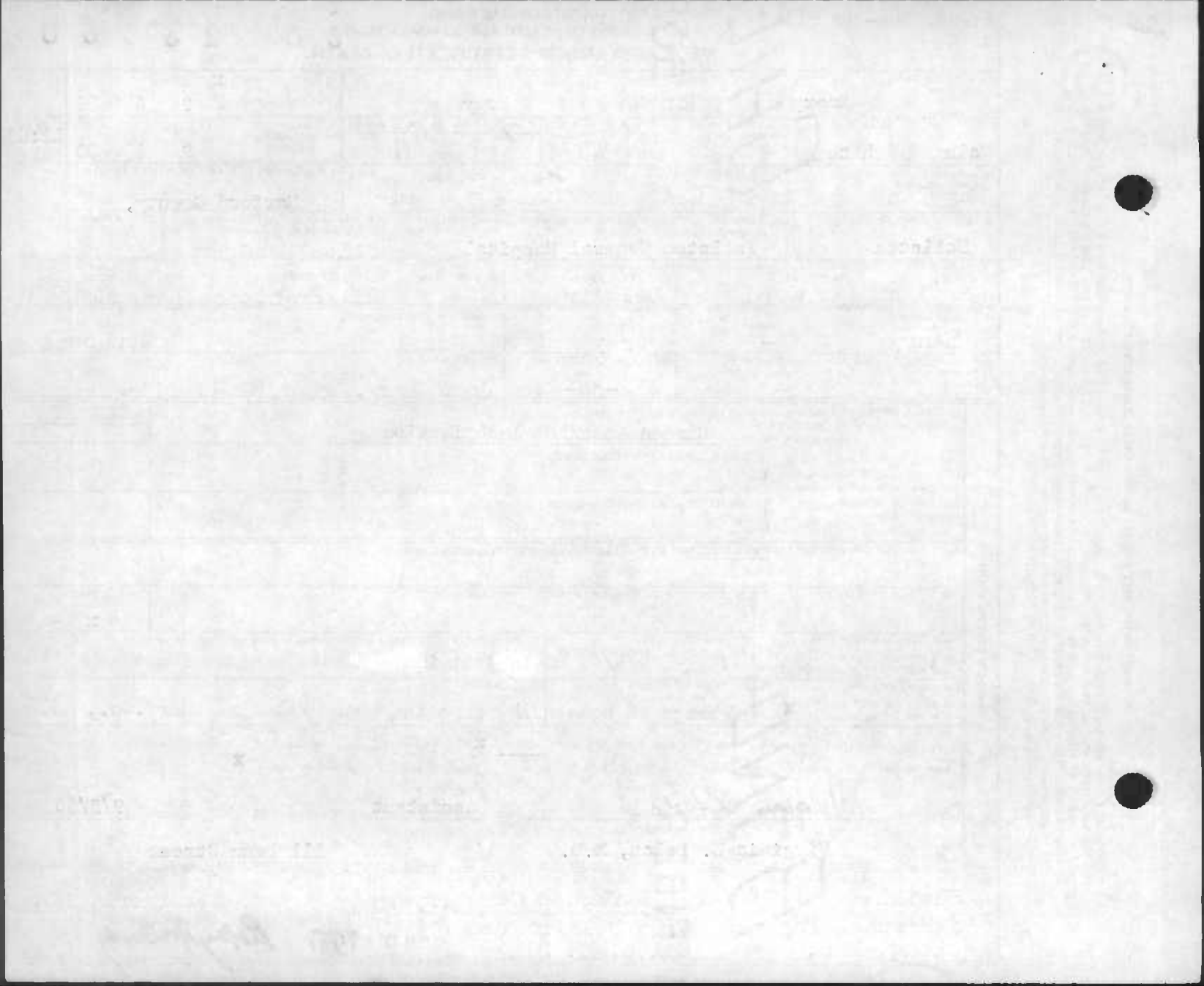
02 15 1918

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE IN THE DIVISION OF VITAL RECORDS. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 7 76

Items #18a-22a Film G547 9/25/80 re STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 0 2 3 5 6 0		
1- STATE REGISTRAR										2a DATE KNOWN OF DEATH		2b HOUR
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Emory Gorman Frey</b>										2c DATE ESTIMATED MONTH DAY YEAR <b>9 4 19 80</b>		2d HOUR <b>11:05 P M</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>4 26 37</b>	6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>43 YRS.</b>	7 IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7 IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 4 19 80</b>		2d HOUR <b>11:05 P M</b>				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County, MD.</b>						
10 CITY OR TOWN OF DEATH <b>Fallston</b>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a STATE <b>Maryland</b>		13b COUNTY <b>Harford</b>		13c CITY OR TOWN <b>Bel Air</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>21014 214 Princeton Lane, Bel Air</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>Henry - Frey</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hazel Countess</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-34-3288</b>		17 INFORMANT ADDRESS <b>Joan Frey, wife, same address</b>								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carbon Monoxide Intoxication</b> 9820 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a												
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 9/4/ 19 80</b>				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject inhaled auto exhaust fumes</b>				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>garage at home</b>				21f LOCATION CITY OR TOWN COUNTY STATE <b>214 Princeton Lane Bel Air Harf. Co., Md.</b>				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .												
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>9/5/80</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>								
23a BURIAL, CREMATION, REMOVAL (PREPARE) <b>Burial</b>		23b. DATE <b>9/8/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>				23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>				
24 FUNERAL DIRECTOR NAME ADDRESS <b>Schimmunek Funeral Home, Inc., 9705 Belair Road Balto, Md. 21236</b>				25a DATE REC'D. BY REGISTRAR <b>SEP 9 1980</b>				25b REGISTRAR SIGNATURE <b>Robert M. Brady</b>				

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. THIS PAGE IS TO BE FILED IN THE OFFICE OF THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED IN THE OFFICE OF THE FUNERAL DIRECTOR. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Ollie		Maudest		Gilkeson				9		3		19		80		2:00	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
F	W	5 2 02		78 YRS.						9		3		19		80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
W. VA.		USA		WIDOWED		DIVORCED		Harford County								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Bel Air		2224 Creswell Rd. Bel Air, MD		Cook		Nursing Home											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
FL		Volusia		Deland		YES <input type="checkbox"/> NO <input type="checkbox"/>		600 S. Florida Ave. Deland, FL									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Robert		Preston		Fisher		Cora		Hayslett									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		234-34-5084		Daughter		2224 Creswell Rd. Bel Air, MD 21014											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4149 ASCVD - Coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE <u>Luis E. Renjel</u>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 9-3-80											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Luis E. Renjel, M.D.		464 Alliance St. Havre De Grace, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Removal		Sept. 3, 1980		Wallace F.H.		Lewisburg-Greenbrier-W.Va.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Howard K. McComas III		Abingdon, Md.		SEP 4 1980		<u>Luis E. Renjel</u>											





SEP 4 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 3 5 6 2			
1 - FOR STATE REGISTRAR				REG NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>FIRST MABEL MIDDLE F. LAST Grinage</b>				2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
<b>September 17 1980</b>				<b>4 35</b>		<b>PM</b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1/29/1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>72</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD	
10 CITY OR TOWN OF DEATH <b>Harvre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hosp.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Minister/Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS	
13a STATE <b>Md</b>		13b COUNTY <b>Harford</b>		13c CITY OR TOWN <b>Aberdeen</b>		<b>514 First St</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Herbert Lee</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lyla Beal</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>217-26-1898</b>		17 INFORMANT ADDRESS <b>Aberdeen, Md. 21001</b> <b>Howard L. Scott, 514 1st. Street</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac De-compensation</b> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.C.U.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>2-3 years.</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>PM 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>7-23 19 80</b> to <b>9-17 19 80</b> , that (I) (we) lost saw the deceased alive on <b>9-17 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b SIGNATURE <b>Edward C. Loo, M.D.</b>				DEGREE <b>M.D.</b>		22c DATE SIGNED <b>9/17/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD C. Loo, M.D.</b>				22e ADDRESS <b>Harvre de Grace, Md. 21078</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>9/20/1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary UAME</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Aberdeen Harford Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Tarring Funeral Home, P.A.</b>				ADDRESS <b>Aberdeen, Md. 21001</b>		25a REGISTERED PHYSICIAN'S SIGNATURE <b>SEP 22 1980</b>	



12

1/25/1950

Ministry of Agriculture

Admission, 10.15.1951  
Howard I. Booth, 31st Street  
217-22-1000

10

1/25/1950  
Howard I. Booth, 31st Street  
217-22-1000  
Admission, 10.15.1951  
Howard I. Booth, 31st Street  
217-22-1000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 6 3

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Frieda Thaxton Haney</i>			2a DATE OF DEATH MONTH DAY YEAR <i>Sept. 15, 1980</i>			2b HOUR <i>2 30 AM</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Aug. 5, 1923</i>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>57</i>		7a IF UNDER 1 YEAR MONTHS DAYS 7b IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Va.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD			
10 CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Mem Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Asst. Supr.</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Telephone</i>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <i>Md. Harford Abingdon</i>			13b INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c STREET ADDRESS <i>701 Long Bar Rd.</i>				
14 FATHER'S NAME FIRST MIDDLE LAST <i>Vivian -- Hamilton</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katie -- Money maker</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>578-22-6506</i>		17 INFORMANT ADDRESS <i>Raymond W. Haney, Abingdon, Md.</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY <i>179- Ca. of uterus &amp; intraabdominal</i> IMMEDIATE CAUSE (a) <i>Metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>?</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>?</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION <i>9-14</i>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>9-15</i>			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <i>9-14</i> 19 <i>80</i> , to <i>9-15</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>9-15</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <i>above</i> (did) (did not) view the body after death.									
22b SIGNATURE <i>Edward C. Loo</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>9/15/80</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward C. Loo, MD</i>			22e ADDRESS <i>Havre de Grace, Md. 21078</i>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b DATE <i>Sept. 19, 1980</i>		23c NAME OF CEMETERY OR CREMATORY <i>Westview Mem. Crematory</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>		
24 FUNERAL DIRECTOR NAME <i>Howard K. McComas III</i>					ADDRESS <i>Abingdon, Md.</i>		25a DATE REC'D. BY REGISTRAR <i>SEP 16 1980</i>		

The medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



SEP 18 1980

SEP 18 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 6 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY HELEN HARKINS		2a. DATE OF DEATH MONTH DAY YEAR 9-13-80		2b. HOUR 3:40 A.M.	
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 3, 1883	
6 AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD CO., MD.			
10 CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Homemaker		13a. STREET ADDRESS 238 Chestnut Hill Road			
13b. STATE Maryland		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Park Enfield		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Henrietta Weeks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-5050		17 INFORMANT (Name) ADDRESS 838-3327 Mr. Walter B. Harkins Forest Hill, Maryland 21050	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Winton Hugh Williams MD		22c. DATE SIGNED 9/13/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Winton Hugh Williams		22e. ADDRESS C/O Falkenberg General Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 15, 1980		23c. NAME OF CEMETERY OR CREMATORY Centre Methodist Con.		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill, Harford Co., Maryland 21050	
24. FUNERAL DIRECTOR Joseph William Foster		25a. DATE REC'D. BY REGISTRAR SEP 15 1980		25b. REGISTRAR'S SIGNATURE Pietro McCreedy			

1883-1884

MARY HOLLAND

Female White June 3, 1883



MAILED CO. x

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				80 23565 REG NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sarah Jane Hasson				2a DATE OF DEATH MONTH DAY YEAR September 3 1980				2b HOUR 1 45 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 15 1891		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		7 IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10 CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem Hosp				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY SAME			
13a STATE Md				13b COUNTY Harford		13c CITY OR TOWN Havre de Grace		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 604 N. Adams St.	
14 FATHER'S NAME FIRST MIDDLE LAST Robert (Wm) Lurch				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen (Wm.) Keatly							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO NO				16b SOCIAL SECURITY NO 217 54 9695		17 INFORMANT ADDRESS HENRY T. PRICE JR. 604 N. ADAMS ST.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Right Lower lobe pneumonia 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Dehydration (c) Generalized atherosclerotic disease PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 9-2-1980 to 9-3-1980 that (I) (we) lost saw the deceased on 9-3-1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b SIGNATURE H. Tanakawa				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/3/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) H. TANAKAWA M.D.				22e ADDRESS 31950 UNION AVE HARVE DE GRACE MD 21046							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 9/6/1980		23c NAME OF CEMETERY OR CREMATORY HOPEWELL METHODIST CEM		23d LOCATION CITY OR TOWN COUNTY STATE NOTTINGHAM Cecil Md					
24 FUNERAL DIRECTOR NAME Cunningham Sons				ADDRESS Havre de Grace, Md.		25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE SEP 8 1980 [Signature]					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23566	
1. DECEASED NAME (TYPE OR PRINT) <b>Raymond (NMN) Hawkins</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>9 11 1980</b>		2b. HOUR <b>4:02 AM</b>			
3 SEX <b>M</b>	4 RACE <b>B</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>6 10 07</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>73 YRS</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 11 1980</b>		7d. HOUR <b>M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b>					
10. CITY OR TOWN OF DEATH <b>Harre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HARFORD Memorial</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Refusee</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>H de Grace</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>805 Garfield Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Carter</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>Feb 43 to Sept 45 717-07-5512</b>		17. INFORMANT ADDRESS <b>Mamie Hawkins 805 Garfield DR. H.D.G. (W.F.C.)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Heart Disease</b> 4149 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. <b>ASCUD</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Luis E Renjel</b>		TITLE (SPECIFY) <b>M.D. Deputy</b>		MEDICAL EXAMINER				DATE SIGNED <b>9-11-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Luis E RENJEL</b>		ADDRESS <b>1164 allman ST. H de Grace</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-15-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. James</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harre de Grace Harford Md.</b>					
24. FUNERAL DIRECTOR NAME <b>ARNOLD W. BEARD</b>		ADDRESS <b>117 Cecil Ave. Md. 21901</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 21 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McBrady</b>					

MEDICAL CERTIFICATION



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 23567	
1. FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) <b>W. RAYMOND HEAPS</b>					2a DATE OF DEATH MONTH DAY YEAR <b>09 23 80</b>		2b HOUR <b>6:40 PM</b>				
3 SEX <b>M</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>9 17 06</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY</b> MD.					
10 CITY OR TOWN OF DEATH <b>FAULSTON, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FAULSTON GENERAL HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HIGHWAY DEPT</b>		12b KIND OF BUSINESS OR INDUSTRY <b>CO. HIGHWAY</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13a STATE <b>PENNSYLVANIA</b>		13b COUNTY		13c CITY OR TOWN <b>FAWN GROVE</b>		13e STREET ADDRESS <b>5016 W. HEAPS RD.</b>					
14 FATHER'S NAME FIRST MIDDLE LAST <b>J. Marion Heaps</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Flora Enfield</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNKNOWN</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>199-24-8956</b>		17 INFORMANT ADDRESS <b>ELSIE HEAPS 5016 W. HEAPS RD. FAWN GROVE, PA.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <b>7/23/73</b> , 19 <b>50</b> , to <b>9 23 80</b> , that (I) (we) lost saw the deceased alive on <b>7/23/73</b> , 19 <b>50</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Stephen H. Pollock</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c DATE SIGNED <b>9/24/80</b>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN H. POLLOCK</b>				22e ADDRESS <b>Fellspring General Hosp</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>9/26/80</b>		23c NAME OF CEMETERY OR CREMATORY <b>St. Paul Methodist</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Pylesville, Harford, Md.</b>					
24 FUNERAL DIRECTOR NAME <b>Kenneth W. Orburn</b> ADDRESS <b>Stewartstown, Pa.</b>				25a DATE REC'D. BY REGISTRAR <b>SEP 23 1980</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 6 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Gertrude Elvira Henning</i>			2a DATE OF DEATH MONTH DAY YEAR <i>September 27 1980</i>		2b HOUR: <i>12 35</i> AM	
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>Sept. 10, 1889</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS	# UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Germany</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Hartford</i> MD.		
10 CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hartford Memorial Hosp.</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		
13a STATE <i>Md</i>			13b COUNTY <i>Hartford</i>		13c CITY OR TOWN <i>Joppa</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Max -- Mevius</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Augusta -- Mueller</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>216-52-9205</i>		17 INFORMANT ADDRESS <i>Mrs. Dorothy H. Guercio, Joppa, Md.</i>		

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), or (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Old age</i> <i>797-</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>9-23</i> 19 <i>80</i> , to <i>9-27</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>9-27</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23a SIGNATURE <i>John D. Yuen</i>		DEGREE		23b DATE SIGNED <i>9/27/80</i>	
23c PHYSICIAN'S NAME (TYPE OR PRINT) <i>John D. Yuen</i>		23d ADDRESS <i>Havre de Grace, Md.</i>		23e ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>Sept. 29, 1980</i>		23c NAME OF CEMETERY OR CREMATORY <i>St. Stephen Cemetery</i>	
23d LOCATION CITY OR TOWN COUNTY STATE <i>Bradshaw Balto Md.</i>		23e DATE REC'D. BY REGISTRAR <i>SEP 29 1980</i>		23f REGISTRAR'S SIGNATURE <i>Robert J. McComas</i>	
24 FUNERAL DIRECTOR NAME <i>Howard K. McComas III</i>		ADDRESS <i>Abingdon, Md.</i>			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 6 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilfred J. Hoffmeister			2a. DATE OF DEATH MONTH DAY YEAR 9 26 80			2b. HOUR 8 4 M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 - 27 - 15		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Aberdeen, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4407 Philadelphia Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Hoffmeister		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Sauers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-6382		17. INFORMANT ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Lung CA. Lt upper lobe with  
1629  
DUE TO, OR AS A CONSEQUENCE OF Brain metastasis.  
(b)  
DUE TO, OR AS A CONSEQUENCE OF Emphysema.  
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

6 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-4-80, 19, to 8-10-80, 19, that (I) (we) last saw the deceased alive on 8-10-80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. PAREKH MD.				DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-29-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD.				22e. ADDRESS 1131 Bel Air Road MD 21014			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 9/26/80		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.				25a. DATE REC'D. BY REGISTRAR OCT 14 1980		25b. REGISTRAR'S SIGNATURE Ruthy Keating	

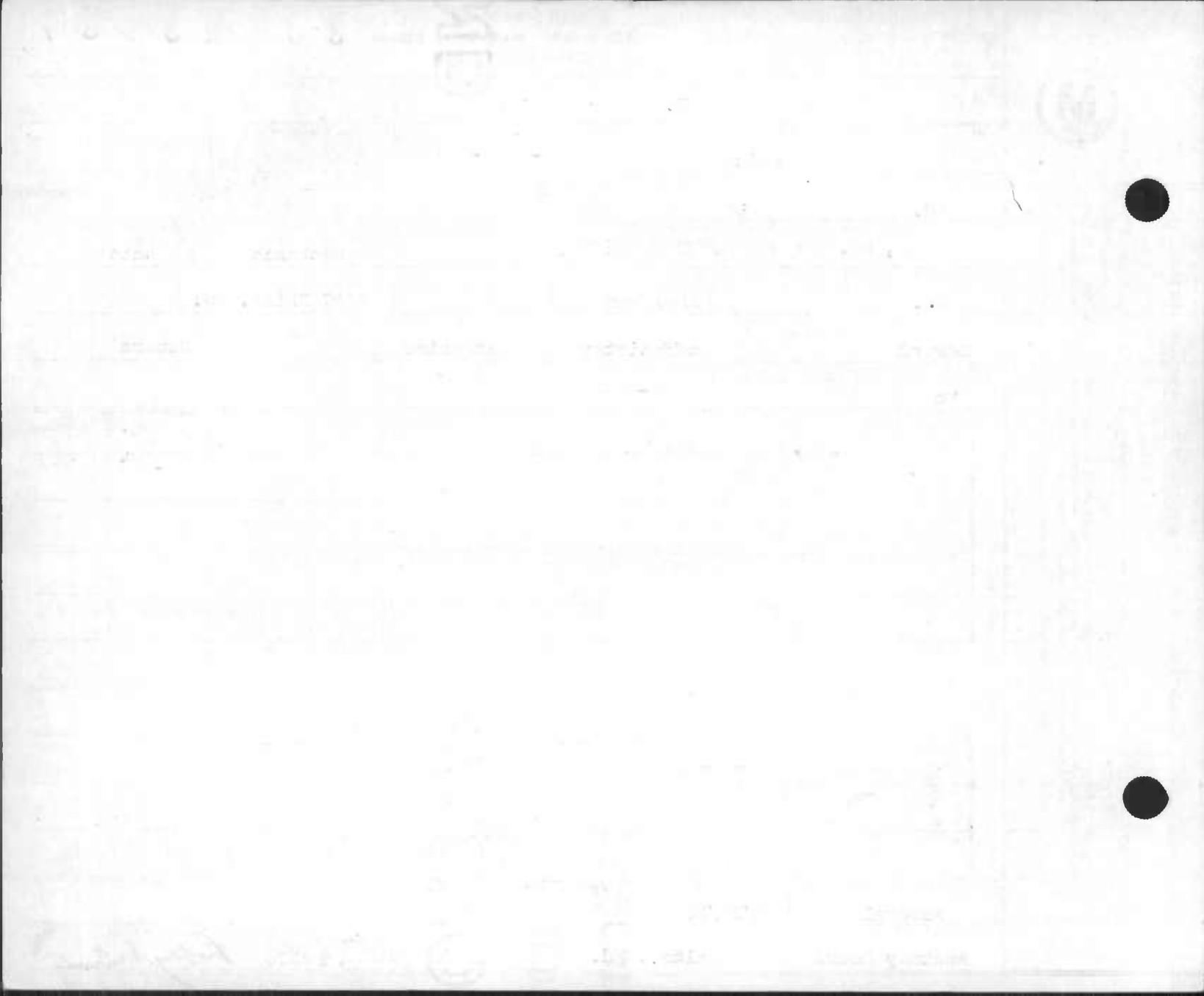
BP

DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	3	5	7	0	
1. FOR STATE REGISTRAR										REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vertie H. Jacobs										2a DATE OF DEATH MONTH DAY YEAR 9 30 1980				2b HOUR 5:00P M			
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 08 06 1882			6 AGE (IN YEARS LAST BIRTHDAY) 98 YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10 CITY OR TOWN OF DEATH Bel Air				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Ctr., Inc.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY n/a							
13a STATE Maryland				13b COUNTY Harford		13c CITY OR TOWN Aberdeen		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 623 W. Bel Air Ave.							
14 FATHER'S NAME FIRST MIDDLE LAST Frederick Hinkson					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Hanson												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-07-1710D		17 INFORMANT Anna J. Threatt				ADDRESS 107 Lamb St., Fayetteville NC							
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5609 High intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (b) 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) 2 days										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 010 Acc							
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (I) (this hospital) attended the deceased from March 19 72 to 9-30-1980 that (I) (we) last received alive or (we) did not view the body after death.										22b SIGNATURE DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> Peter F. Rodman, M.D. 8 Law St. Aberdeen, Md.				22c DATE SIGNED 19-1-80			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 2 Oct. 1980		23c NAME OF CEMETERY OR CREMATORY Bakers Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Maryland									
24 FUNERAL DIRECTOR NAME Tarring Funeral Home, 333 S Parke St. Aberdeen						ADDRESS Md. 21001		25a DATE RECD. BY REGISTRAR OCT 3 1980		25b REGISTRAR'S SIGNATURE [Signature]							

2000:2 DEPT: 20

2000:2 DEPT: 20

2000:2 DEPT: 20

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at \_\_\_\_\_.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 80 23571					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRIEDRICH HEYN KELLY					2a DATE OF DEATH MONTH DAY YEAR 9-3-80					2b HOUR 9:38 PM
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 7-12-95		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7 UNDER 1 YEAR MONTHS DAYS 85		7 UNDER 74 HRS HOURS MIN. 85
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD				
10 CITY OR TOWN OF DEATH FALLSTON, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b KIND OF BUSINESS OR INDUSTRY Agriculture		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13a STATE Maryland		13b COUNTY Harford Co.		13c CITY OR TOWN Bel Air		13e STREET ADDRESS 502 West Gordon Street				
14 FATHER'S NAME FIRST MIDDLE LAST Howard Atwood Kelly					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olga Elizabeth Laetitia Bredow					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17 INFORMANT (NAME) Mrs. Margaret S. Kelly		17 ADDRESS 502 West Gordon Street Bel Air, Maryland 21014				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 185- UPPER GI Bleeding - ? D.I.C. DUE TO, OR AS A CONSEQUENCE OF (b) CA. Prostate (c) DUE TO, OR AS A CONSEQUENCE OF ASCVD, Emphysema. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Hours
MEDICAL CERTIFICATION										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE B. PAREKH MD.						DEGREE MD.		22c DATE SIGNED 9-3-80		
22d PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD.						22e ADDRESS 1131 Bel Air Road MD. 21014				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Sept. 6, 1980		23c NAME OF CEMETERY OR CREMATORY DEER CREEK Meth. Ch. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Forest Hill, Harford Co., Maryland 21050			
24 FUNERAL DIRECTOR Joseph William Foster Superior Life						25 SEP 8 1980				

(N)

28

7-12-82

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23572	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace D. Kerr						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 12 1980		2b. HOUR 10 AM	
3. SEX F		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 10-11-99		6. AGE (IN YEARS) YRS. 80		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD					
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Hartford		13c. CITY OR TOWN Whiteford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1555 Kerr Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST CHALKLEY DEMPSEY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA KING					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-74-8211		17. INFORMANT ADDRESS MERTON A. KERR, WHITEFORD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last: (b) <u>Arteriosclerotic Heart Disease</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Willard R Amos				TITLE (SPECIFY) M.D. 23572				MEDICAL EXAMINER DATE SIGNED 9/12/80			
EXAMINER'S NAME (TYPE OR PRINT) Willard R Amos				ADDRESS 2404 Pleasantville Rd Fallston Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-14-80		23c. NAME OF CEMETERY OR CREMATORY SLATEVILLE				23d. LOCATION CITY OR TOWN COUNTY STATE DELTA YORK PA.			
24. FUNERAL DIRECTOR NAME JOHN H. HARKINS, DELTA, PA.				25. DATE REC'D. BY REGISTRAR SEP 15 1980				26. REGISTRAR'S SIGNATURE Rita McCreedy			



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 3 5 7 3

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FRANCES		FIRST MIDDLE LAST RIGHT		2a DATE OF DEATH MONTH DAY YEAR 09 18 80		2b HOUR 7:50 AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 01 - 29 - 23		6 AGE (IN YEARS, LAST BIRTHDAY) 57 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10 CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b KIND OF BUSINESS OR INDUSTRY Maryland National	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY HARFORD		13c CITY OR TOWN TOPPATOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 522 ECKART DRIVE	
14 FATHER'S NAME FIRST MIDDLE LAST James Wojciechowski		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Bungart		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-18-5870		17 INFORMANT ADDRESS NAXWELL RIGHT 522 ECKART DRIVE TOPPATOWN	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MASSIVE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) <u>did</u> attend the deceased from <u>9/11</u> 19 <u>80</u> , to <u>9/18</u> 19 <u>80</u> , that (I) <u>have</u> last saw the deceased alive on <u>9/17</u> 19 <u>80</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I <u>was</u> (did) <u>not</u> view the body after death.							
22b SIGNATURE <u>David R. Padrino</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/18/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DAVID R. PADRINO		22e ADDRESS 57 E. Broadway, Bel Air, Md.					

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9-22-80		23c NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME Charles L. Stevens Funeral Home, Inc.		ADDRESS 1501 E. FORT AVE		25a DATE REC'D. BY REGISTRAR SEP 19 1980		25b REGISTRAR'S SIGNATURE <u>David R. Padrino</u>	

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THEORY OF THE EARTH  
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521-13

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-2. RETAIN PAGE 3 AS YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23574	
1. DECEASED NAME (TYPE OR PRINT) <b>Up Soo Park Kim</b>						7a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 19		7b. HOUR <b>M</b>			
3. SEX <b>F</b>	4. RACE <b>Korean</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6/3/16</b>	6. AGE IN YEARS (LAST BIRTHDAY) <b>65</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 26 1980</b>		2d. HOUR <b>1058</b> M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KOREA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Hartford</b> MD					
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GEN. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ITSLC</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>Hartford</b>		13c. CITY OR TOWN <b>Abingdon</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>49 Boxthorn Rd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JENNIS PARK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHOI</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218 92 2709</b>		17. INFORMANT <b>ANDREW KIM</b>				ADDRESS <b>A BOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 8121 Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) <b>Multiple Trauma, Head Injury</b> (c) <b>2 hours</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8 P.M. 9 26 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) <b>Front seat passenger; collision occurred</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Intersection Rt 40 + 755</b>		21f. LOCATION CITY OR TOWN <b>Abingdon</b> COUNTY <b>Hartford</b> STATE <b>MD</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Willard R. Amos</b>			TITLE (SPECIFY) <b>Asst Dir</b>		MEDICAL EXAMINER		DATE SIGNED <b>9/27/80</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Willard R Amos</b>			ADDRESS <b>2404 Pleasantville Rd Fallston Md</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/30/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>			23d. LOCATION CITY OR TOWN <b>BACTO</b> COUNTY <b>MD</b> STATE <b>MD</b>				
24. FUNERAL DIRECTOR NAME <b>J. G. CONNELLY</b> ADDRESS <b>300 MACE</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 6 1980</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 3 5 7 5			
1 - FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GILBERT HENRY KREUL				2a DATE OF DEATH MONTH DAY YEAR 09 28 80		2b HOUR 4:20 AM	
3 SEX M	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 07 12 20		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7 UNDER 1 YEAR # UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA	7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD		
10 CITY OR TOWN OF DEATH FALLSTON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS 950 B HILLSWOOD RD.	
13a STATE MARYLAND	13b COUNTY HARFORD	13c CITY OR TOWN FALLSTON	14 FATHER'S NAME FIRST MIDDLE LAST William Edward Kreul				
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Bridget O'Brien			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				
16b SOCIAL SECURITY NO. 473-07-564			17 INFORMANT HAZEL KREUL 950 B HILLSWOOD RD, FALLSTON				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY FAILURE 492- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CHRONIC LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) EMPHYSEMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SEPTICEMIA							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23a SIGNATURE Dante N. Monakil				DEGREE		23b DATE SIGNED 9/28/80	
23c PHYSICIAN'S NAME (TYPE OR PRINT) DANTE N. MONAKIL				23d ADDRESS Fallston Gen Hosp. Fallston, Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b DATE Sept. 28, 1980		23c NAME OF CEMETERY OR CREMATORY Brown Funeral Home		23d LOCATION CITY OR TOWN COUNTY STATE Lohrville-Calhoun-Iowa	
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.				25a DATE REC'D. BY REGISTRAR SEP 30 1980		25b REGISTRAR'S SIGNATURE Ricky Reddy	





CHRONIC LUNG DISEASE  
PULMONARY FAILURE  
EMPHYSEMA

SEPTICEMIA

INTE N MONAKIL  
PENT R MONAKIL  
1/1/19

SEP 28 1980

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Item 185 G547 9/18/80 dad

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Catherine Kuenzler</b>			2a DATE OF DEATH MONTH DAY YEAR <b>Aug 25, 1980</b>			2b HOUR <b>10<sup>45</sup> P.M.</b>				
3 SEX <b>female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>9-20-94</b>		6 AGE (IN YEARS, LAST BIRTHDAY) <b>85</b> YRS.		7 USUAL PLACE OF BIRTH MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD				
10 CITY OR TOWN OF DEATH <b>Bel Air</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bel Air Convalescent Center</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Silk Warper</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Textile</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD.</b>					13b COUNTY <b>Harford</b>		13c CITY OR TOWN <b>Bel Air</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Edward Kuenzler</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Julia Linggenhager Kingenholder</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>143-07-4655A</b>			17 INFORMANT (NAME, ADDRESS) <b>Shirley Kuenzler, 309 Prospect Mill Rd Bel Air</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CVA</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive heart disease</b> <b>-HHTD/ASHD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASHD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>										
19a DATE OF OPERATION <b>None</b>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NA</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>NA</b>				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <b>NA</b>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NA</b>			21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>NA</b>				
22a I certify that (1) (this hospital) attended the deceased from <b>July 12</b> 19 <b>79</b> to <b>Aug 25</b> 19 <b>80</b> that (1) (we) lost saw the deceased alive on <b>Aug 25</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>A. J. Juliano</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <b>8/25/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. J. Juliano, M.D.</b>						22e ADDRESS <b>1604 Churchville Rd Bel Air Md</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b DATE <b>August 27, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland 21202</b>		
24 FUNERAL DIRECTOR <b>Joseph William Foster</b>			W. Brown Way & Williams St. Bel Air, Maryland 21014			25a DATE REC'D. BY REGISTRAR <b>AUG 27 1980</b>		25b REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>		

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 3 5 7 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William John Linder			2a. DATE OF DEATH MONTH DAY YEAR Sept. 4 1980		2b. HOUR 3:07 PM	
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 3 5 1913		
6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD		10 CITY OR TOWN OF DEATH HARFORD				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b KIND OF BUSINESS OR INDUSTRY Contractor		
13a STATE MD.		13b COUNTY HARFORD		13c CITY OR TOWN Aberdeen		
14 FATHER'S NAME FIRST MIDDLE LAST Gordon Linder		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Foley				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1930		17 INFORMANT ADDRESS Margaret Linder, 269 Paradise Rd., Aberdeen, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 9-1, 1980, to 9-4, 1980, that (I) (we) last saw the deceased alive on 9-4, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Brian T. Yeager M.D.		DEGREE M.D.		22c DATE SIGNED 9/4/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8 Sep. 1980		23c NAME OF CEMETERY OR CREMATORY Mt. Erin Cemetery		
23d LOCATION CITY OR TOWN COUNTY STATE Harford, Md.		23e LOCATION CITY OR TOWN COUNTY STATE Harford, Md.				
24 FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001		25 DATE RECEIVED BY REGISTRAR SEP 10 1980		25 REGISTRAR'S SIGNATURE [Signature]		

BP \_\_\_\_\_

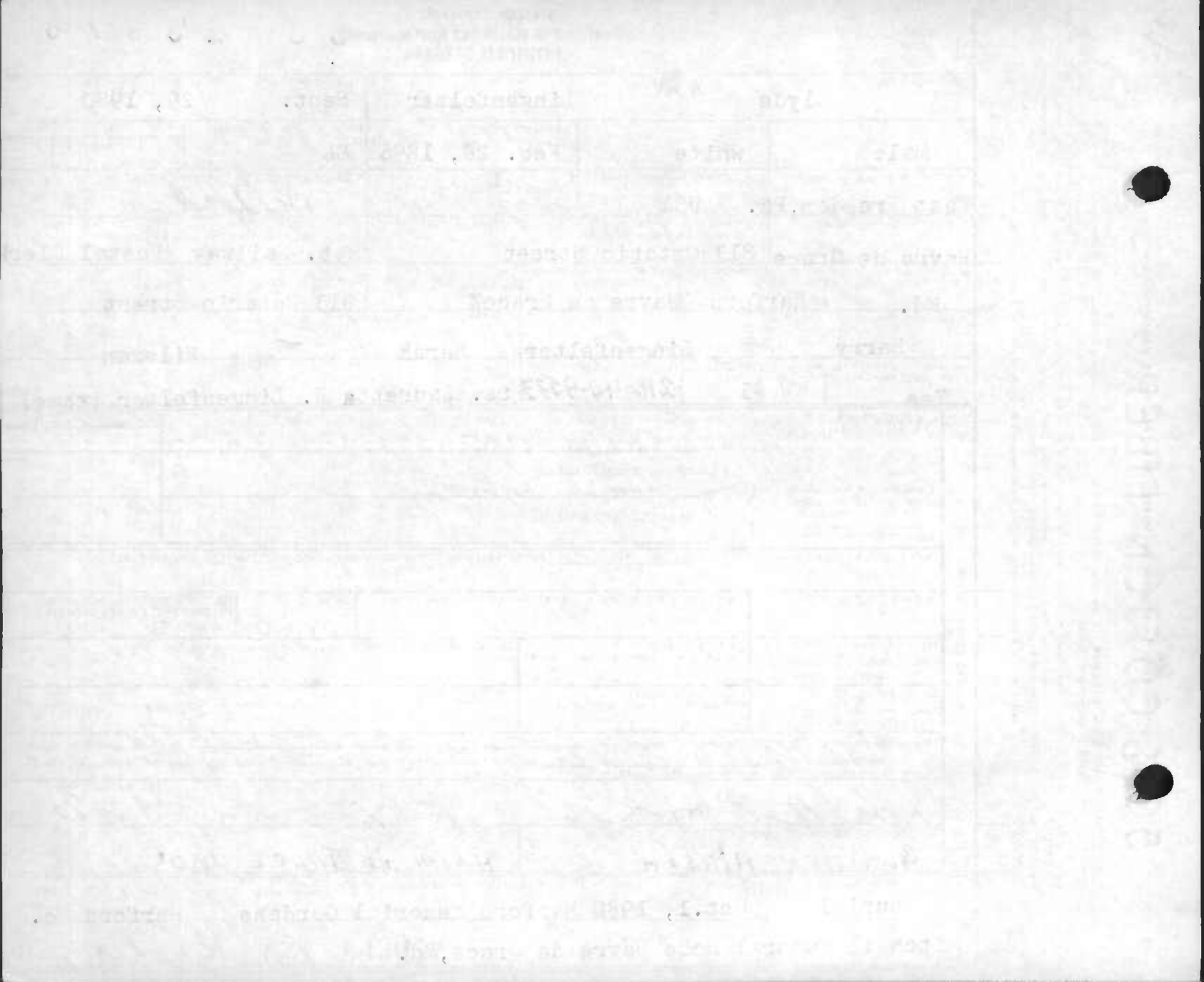


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1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		REG. NO. 0 0 2 3 5 7 8	
1 DECEASED NAME (TYPE OR PRINT)		3 SEX	4 RACE	5 DATE OF BIRTH	6a DATE OF DEATH
Clyde <sup>MIDDLE</sup> NMN Lingenfelter		Male	white	Feb. 28, 1896	Sept. 29, 1980
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
East Freedom, Pa.	USA		Harford MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
Harre de Grace	813 Ontario Street		Ret. Railway		Postal Clerk
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS	
Md.	Harford	Harre de Grace	NO <input type="checkbox"/>	813 Ontario Street	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		17 INFORMANT	
Harry Lingenfelter		Sarah Hileman		Mrs. Lauretta B. Lingenfelter (same)	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 ADDRESS	
Yes		WW #1		216-44-9533	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>Cardiac arrhythmia</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 1-7 19-80 to 9-29 19-80 that (I) (we) last saw the deceased alive on 1-10 19-80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) move the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
<u>GUNTHER HIRSEH</u>				9-30-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
GUNTHER HIRSEH		HAYRE DE GRACE, MD.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		Oct. 1, 1980		Harford Memorial Gardens	
24 FUNERAL DIRECTOR		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Mitchell Funeral Home Havre de Grace, Md.		OCT 3 1980		<u>Patricia M. Hardy</u>	





Item 18-22a Film G 549 11/5/80 GB STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 2 3 5 7 9

1. DECEASED NAME (TYPE OR PRINT) Carolyn B. Lowe				2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 9 2 19 80				2b. HOUR M M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 20, 1961		6. AGE (IN YEARS) (LAST BIRTHDAY) 19 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Food	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Pylesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 4909 Fawn Grove Road			
14. FATHER'S NAME FIRST MIDDLE LAST B. LeRoy Lowe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma McRoberts					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-82-0523		17. INFORMANT 4909 Fawn Grove Road B. LeRoy Lowe, Pylesville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute doxepin intoxication 9503 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9-2- 19 80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) ingested doxepin			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4909 Fawn Grove Rd. Pylesville, Harford, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) Deputy Chief				MEDICAL EXAMINER DATE SIGNED 9/3/80	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept. 6, 1980		23c. NAME OF CEMETERY OR CREMATORY Slate Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Delta York Penna.	
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main Street, Delta, Penna.				25a. DATE RECORDED BY REGISTRY SEP 8 1980		25b. REGISTERED BY <i>Larry McHenry</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

SEP 8 1950

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE STREET AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMHM - 17  
(VR A15 ME (5))  
15M 7/77

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

23580

1. DECEASED NAME (TYPE OR PRINT) <b>Rebecca Kyle MacRae</b>						2a. DATE KNOWN OF DEATH ESTI. <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>9 22 19 80</b>		2b. HOUR <b>10 P M</b>	
3. SEX <b>F</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>14</b> YEAR <b>1983</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>86</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD MONTH <b>9</b> DAY <b>24</b> YEAR <b>19 80</b>		7d. HOUR <b>9 09 P M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Hartford</b> MD			
10. CITY OR TOWN OF DEATH <b>Bel Air</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>309 Wheel Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Hartford</b>		13c. CITY OR TOWN <b>Bel Air</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>309 Wheel Road</b>	
14. FATHER'S NAME FIRST <b>Edwin</b> MIDDLE <b>Deweese</b> LAST <b>Kyle</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Anne</b> MIDDLE <b>Wingate</b> LAST <b>Haigh</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-46-8442</b>		17. INFORMANT ADDRESS <b>Mrs. Anne M. Bouton, Bel Air, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>4140</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (c) <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: "Natural causes" <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <b>Willard P. Amoss</b>			TITLE (SPECIFY) <b>Asst Reg</b>		MEDICAL EXAMINER		DATE SIGNED <b>9/25/80</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Willard P Amoss</b>			ADDRESS <b>2404 Pleasantville Rd, Fallston Md 21047</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 27, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Abingdon Hartford Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III</b> ADDRESS <b>Abingdon, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1980</b>		25b. REGISTRAR SIGNATURE <b>Anthony McCreary</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

BP

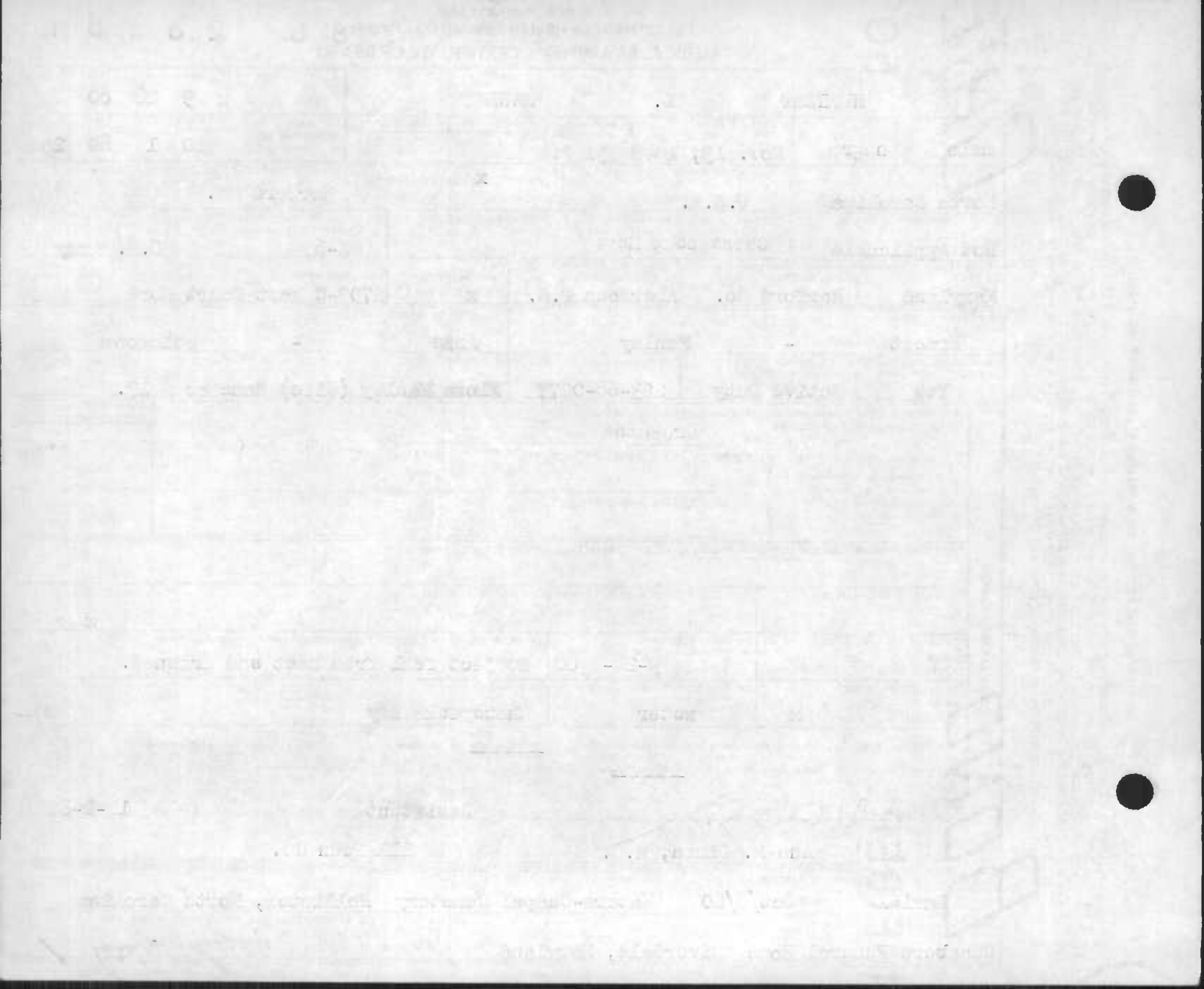
DHMH - 17  
(VIR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
HERBERT L. MANLEY			MONTH DAY YEAR 9 28 80			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	8. MONTH DAY YEAR	8. HOUR
male	negro	Nov. 13, 1948	31 YRS.			10 1 80	2p	M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
North Carolina			U.S.A.			Harford Co.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Not Applicable			Chesapeake Bay			E-6 U.S. Army		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Harford Co.			Aberdeen P.D.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
Ernest - Manley			Anne - Solomon			223-68-0277		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Yes Active Duty			223-68-0277			Flora Manley (Wife) Same as # 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: Drowning								
IMMEDIATE CAUSE (a) 8329								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR ? P.M. 9-28-80		Subject fell from boat and drowned.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			water		Chesapeake Bay Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Ann M. Dixon, M.D.			Assistant			10-2-80		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Ann M. Dixon, M.D.			111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			Oct/8/80			Waters-Chapel Cemetery		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Chambers Funeral Home			OCT 10 1980			[Signature]		
NAME			ADDRESS					
Chambers Funeral Home			Riverdale, Maryland					



Items #5 per phone call w/Fun. Home STATE OF MARYLAND  
 FOR 10/3/80 re DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 1- STATE REGISTRAR CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLEN MARSHALL		2a DATE OF DEATH MONTH DAY YEAR 9 30 80		2b HOUR 4:05 P.M.	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 9 30 1980		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD	
10 CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CITIZEN NURSING HOME		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE Maryland	13b COUNTY Harford	13c CITY OR TOWN Aberdeen	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 29 Mitchell Avenue	
14 FATHER'S NAME FIRST MIDDLE LAST Frederick Brown		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Brown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 345-26-6746		17 INFORMANT ADDRESS Helen Messenger, 29 Mitchell Ave., Aberdeen, Md. 21001	

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cerebral Thrombosis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 WEEK

4340  
 Conditions, if any, which  
 gave rise to immediate  
 cause (a), stating the  
 underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

Cerebral atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

&gt; 5 YEARS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

arteriosclerotic heart disease

## MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the hospital) attended the deceased from 4-23 19 76 to 9-30 19 80, that (I) (we) last saw the deceased alive on 9-30 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE B. J. Plunkett, M.D.				DEGREE M.D.		22c DATE SIGNED 9-30-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) B. J. Plunkett, M.D.				22e ADDRESS 617 W. Bel Air Avenue, Aberdeen, Md. 21001			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 3 Oct. 1980	23c NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens	23d LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland
24 FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001		25a DATE REC'D. BY REGISTRAR OCT 3 1980	25b REGISTRAR'S SIGNATURE [Signature]



1. Name of the person or organization to whom the report is made: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

2. Name of the person or organization making the report: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

3. Title of the report: Report of the Federal Bureau of Investigation, Washington, D.C.

4. Date of the report: January 1, 1961

5. Name of the person or organization to whom the report is made: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

6. Name of the person or organization making the report: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

7. Title of the report: Report of the Federal Bureau of Investigation, Washington, D.C.

8. Date of the report: January 1, 1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL).

BP

DHMH 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John David Meyer			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 29 1980		2b. HOUR M 1 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1961	6. AGE (IN YEARS) (LAST BIRTHDAY) 18 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS. HOURS MIN.
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	
13a. STATE Maryland		13b. COUNTY Harford Co.	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LEO FRANCIS MEYER, Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELSIE DELPHINE MATTER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-72-5431		17. INFORMANT (NAME) ADDRESS (UNLISTED HOME) (PHONE) 836-2344 MR. LEO F. MEYER, Jr. 1405 REVERE COURT BEL AIR, MARYLAND 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio cerebral injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <u>11</u> MONTH DAY YEAR P.M. 9 28 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) impact occupant ejected during auto/fixed object	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN Rt. 136 s. of Trappe Church Rd, Darlington, Harford Co., MD.	
22a. I certify that I took charge of the remains described above, held on, death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Thomas D. Smith</i>		TITLE (SPECIFY) Deputy Chief		DATE SIGNED 9/30/80	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cath. Ch. Cem.	
23d. LOCATION CITY OR TOWN Forest Hill, Harford Co., Maryland 21050		COUNTY Harford			
24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams Sts Bel Air, Maryland 21014		25. DATE REC'D. BY REGISTRAR OCT 3 1980			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI. DEATH MATED		MONTH		DAY		YEAR		2b. HOUR 4:15 AM	
3. SEX M		4. RACE Cone		5. DATE OF BIRTH MONTH DAY YEAR 3 28 18		6. AGE (IN YEARS) (LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 9 13 1980		2d. HOUR 4:15 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD											
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WEST. ELEC.		12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6722 Mallard Road									
14. FATHER'S NAME FIRST MIDDLE LAST MADISON MULES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 215-03-4167		17. INFORMANT HELEN MULES		ADDRESS ABOVE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) Arteriosclerotic Heart Disease (c) Cardiac Arrest with Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE Willard R. Amoss		TITLE (SPECIFY) M.D. 1958		MEDICAL EXAMINER		DATE SIGNED 9/13/80											
EXAMINER'S NAME (TYPE OR PRINT) Willard R. Amoss		ADDRESS 2404 Prosser Avenue, Fallston, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/15/80		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.											
24. FUNERAL DIRECTOR NAME J. G. CONNELLY		ADDRESS SONS 300 MA CE		25a. DATE REC'D. BY REGISTRAR SEP 19 1980		25b. REGISTRAR'S SIGNATURE notary/Amoss											

Handwritten notes on lined paper, including a date stamp "FEB 18 1932" and a circular stamp.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

23585

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN MARIE NOLAN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Sept 16 80</b>		2b. HOUR <b>6 55 AM</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 31 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD MD</b>
10. CITY OR TOWN OF DEATH <b>HAURE DE GRACE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HARFORD Memorial Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE KEEPER</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD</b> 13c. COUNTY <b>HARFORD</b> 13d. CITY OR TOWN <b>HAURE DE GRACE</b> 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13a. STREET ADDRESS <b>900 ONTARIO STREET</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Dudek</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Theresa Peucha</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO <b>192-22-9301</b>		17. INFORMANT ADDRESS <b>4001 ROCK RUN RD. DOROTHY M. WORTHINGTON HAURE DE GRACE MD</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CA Pancreas with liver metastasis</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>1 MONTH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>8-8</b> 19 <b>80</b> to <b>9-16</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>9-16</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>B. PAREKH</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/16/80</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. PAREKH MD.</b>		22e. ADDRESS <b>1131 Bel Air Road BELAIR MD 21014</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>SEPT. 18 1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROCKS RUN</b>		23d. LOCATION CITY OR TOWN <b>HARFORD</b> COUNTY STATE <b>MD.</b>
24. FUNERAL DIRECTOR NAME <b>MITCHELL FUNERAL HOME P.A.</b> ADDRESS <b>HAURE DE GRACE MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 22 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. ...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MARIE

Oct 31 1901

Retired

Street

Back

193-33-3501  
1901  
Washington

(District)

WHEEL FURNACE  
26953  
BARNARD  
BARNARD



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 8 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLARA AYRES MORRIS			2a DATE OF DEATH MONTH DAY YEAR 09/24/80		2b HOUR 1:30 PM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 10/18/1893		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD	
10 CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b KIND OF BUSINESS OR INDUSTRY Farming
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY BALTIMORE 13c CITY OR TOWN WHITE HALL			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 2912 HUNTER MILL RD.
14 FATHER'S NAME FIRST MIDDLE LAST Thomas J. Ayres		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah May Carlin			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 215-40-0115		17 INFORMANT CATHERINE ENSOR 2912 HUNTER MILL RD WHITE HALL MD	

11 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CAUDAL ABRUPTIO

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

410-

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) ACUTE MI

DUE TO, OR AS A CONSEQUENCE OF

(c) ARTERIOCORONARY CIRCULATORY DISEASE

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Aspiration

## MEDICAL CERTIFICATION

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:30 P.M. 9 24 1980	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 9/23 19 80, to 9/24 19 80, that (I) (we) last saw the deceased alive on 9/24 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE Marilyn J. MacVey MD	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/24/80
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARILYN J. MACVEY		22e ADDRESS FALLSTON GEN HOSPITAL	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 9/26/1980	23c NAME OF CEMETERY OR CREMATORY McKendree Cem.	23d LOCATION CITY OR TOWN COUNTY STATE Black Horse Harford, Md.
24 FUNERAL DIRECTOR NAME M. G. Kurtz III		ADDRESS Jarrettsville, Md.	

RECEIVED  
JAN 10 1962

100-100000-100000

100-100000-100000

100-100000-100000

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100-100000-100000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(V.R. 115 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		700 23587	
1 DECEASED NAME (TYPE OR PRINT)			
Richard Carroll Novak Jr.			
3 SEX Male		4 RACE White	
5 DATE OF BIRTH MONTH DAY YEAR 3 25 62		6 AGE (IN YEARS) LAST BIRTHDAY 18 YRS.	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Md.		7b CITIZEN OF WHAT COUNTRY? U.S.AA	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD	
10 CITY OR TOWN OF DEATH Bel Air <del>Baltimore</del>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. #136, N. of Hookers Mill Rd.	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.			
13b COUNTY Harford		13c CITY OR TOWN Bel Air	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 2628 Calvary Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Richard C. Novak Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elmira Gephardt	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO.	
17 INFORMANT Richard Novak		ADDRESS 2628 Calvary Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:15xx 9 24 19 80	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by hit & run vehicle			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street	
21f LOCATION STREET CITY OR TOWN COUNTY STATE Rt. #136, N. of Hookers Mill Rd., Harford Co., Maryland			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9/27/80	
23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24 FUNERAL DIRECTOR NAME B. Dabrowski & Son		24b ADDRESS 2818 E. Baltimore St.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 8 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>SALVADORE — PASQUA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 - 2 - 80</b>			2b. HOUR <b>8:30 AM</b>					
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5 1 22</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>58 YRS</b>		7 UNDER 1 YEAR MONTHS DAYS <b>8 20</b>		7 UNDER 24 HRS HOURS MIN <b>8 20</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY MD</b>					
10 CITY OR TOWN OF DEATH <b>FALLSTON, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GENERAL HOSP.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner Carry Out</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE <b>Maryland</b>		13b COUNTY <b>Harford</b>		13c CITY OR TOWN <b>Forest Hill</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>206 Melissa Way</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Pasqua</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances J Raymond</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WW 11</b>		17 INFORMANT <b>Mrs Dolores Pasqua</b>				ADDRESS <b>Same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>410 - Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Arrest 2° to MI / Pulm Embolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>8/18/80</b> to <b>9/2/80</b> , that (I) (we) lost sight of the deceased above <b>1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>[Signature]</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>9/2/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. S. NAIR MD</b>				22e ADDRESS <b>1716 Harford Road, Fallston, MD 21034</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b DATE <b>8/5/80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Leonard JRuck Inc.</b>				ADDRESS <b>Baltimore, Maryland</b>				25a DATE REC'D. BY REGISTRAR <b>SEP 4 1980</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	

(M)

*Handwritten signature*

SEP 1 1980

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Raymond		MIDDLE G.		LAST Pease		20. DATE KNOWN OF DEATH		ESTIMATED 8 9 27 19 80		26. HOUR 2:15 P.M.	
3. SEX M	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 7 17 63		6. AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 27 19 80		7d. HOUR 2:15 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Y. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. Md. MD.							
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor				12b. KIND OF BUSINESS OR INDUSTRY Dundalk PortA.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 922 Jackson Blv, Belair, Md.					
14. FATHER'S NAME FIRST MIDDLE LAST James Ira Pease						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Cahill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Navy -YES- W. W. II				16b. SOCIAL SECURITY NO. 133-01-5787		17. INFORMANT ADDRESS Elizabeth Pease, 700 E. 3rd. St. Brooklyn, N.Y.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable Massive Myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Willard R Amoss				TITLE (SPECIFY) M.D. Asst Dir				MEDICAL EXAMINER DATE SIGNED 9/27/80					
EXAMINER'S NAME (TYPE OR PRINT) Willard R Amoss				ADDRESS 2404 Pleasantville Rd, Fallston									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-2-1980		23c. NAME OF CEMETERY OR CREMATORY Pine Lawn Natl. Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Long Island New York					
24. FUNERAL DIRECTOR NAME E. F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087						25a. DATE REC'D. BY REGISTRAR SEP 30 1980				25b. REGISTRAR'S SIGNATURE R. J. Brandy			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201






 1 - FOR  
STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 9 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>RIKEY HERMAN POOLE</b>				2a DATE OF DEATH MONTH DAY YEAR <b>9-3-80</b>				2b HOUR <b>6<sup>55</sup> A M</b>	
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>12 6 99</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		7 UNDER 1 YEAR MONTHS DAYS <b>80</b>	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA-VIRGINIA</b>		7c CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD Co.</b> MD			
10 CITY OR TOWN OF DEATH <b>FALLSTON</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GENERAL Hosp.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer &amp; construction</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
13a STATE <b>Maryland</b>				13b COUNTY <b>Harford Co.</b>		13c CITY OR TOWN <b>Bel Air</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Wesley POOLE</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Matilda Roberts</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b SOCIAL SECURITY NO <b>220-30-1164</b>		17 INFORMANT (NAME) & ADDRESS <b>Mrs. Verna M. Poole 2101 Helton Avenue Bel Air Maryland 21014</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY <b>410 - ASYSTOLE &amp; EM DISSOCIATION</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/31/80</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>8/31/80</b> 19 <b>80</b> to <b>9/3/80</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9/3/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.									
22b SIGNATURE <b>Joseph Reinhardt</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>9/30/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH A. REINHARDT, M.D.</b>						22e ADDRESS <b>2003 Rock Spring Rd, Forest Hill, Maryland 21050</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>Sept. 5, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air, Harford Co., Maryland 21014</b>		
24 FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>Superior Funeral</b>						25a DATE RECEIVED BY REGISTRAR <b>SEP 4 1980</b>			



8-3-10-10-10-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 2 3 5 9 1	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Thomas RHODY		2a DATE OF DEATH MONTH DAY YEAR 9 12 80		2b HOUR 4 53 AM	
3 SEX Female	4 RACE Caucasion	5 DATE OF BIRTH MONTH DAY YEAR Jan. 19 1893	6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS	7 IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD		
10 CITY OR TOWN OF DEATH FALLSTON	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland		13b COUNTY Harford	13c CITY OR TOWN Bel Air	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 129 West Gordon Street
14 FATHER'S NAME FIRST MIDDLE LAST Peter Oscar Thomas		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Melinda Thomas			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) NONE	17 INFORMANT ADDRESS Evelyn R. Johnson Bel Air, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Ant. Lateral Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic Shock. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 9-5 19 80 to 9-12 19 80, that (I) (we) last saw the deceased alive on 9-12 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE B. PAREKH MD		DEGREE MD - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/12/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD		22e ADDRESS 1131 Belair Rd Belair MD 21014			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL	23b DATE Sept. 12, '80	23c NAME OF CEMETERY OR CREMATORY Vaughn-Guynn F.H.		23d LOCATION CITY OR TOWN Galax	COUNTY STATE Grayson Virginia
24 FUNERAL DIRECTOR NAME Howard K. McComas III		ADDRESS Abingdon, Maryland		25a DATE REC'D. BY REGISTRAR SEP 15 1980	25b REGISTRAR'S SIGNATURE D. McCreedy

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 5 9 2  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE V. ROCKEY		2a. DATE OF DEATH MONTH DAY YEAR September 21, 1980	
3 SEX Female		4 RACE White	
5 DATE OF BIRTH MONTH DAY YEAR October 3, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10 CITY OR TOWN OF DEATH Street		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3113 Dublin Road	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Harford	
13c. CITY OR TOWN Street		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 3113 Dublin Road			
14 FATHER'S NAME FIRST MIDDLE LAST Joseph E. Motson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma M. Johnson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-62-6633	
17 INFORMANT Eugene F. Rockey, 3113 Dublin Road, Street, Maryland 21154			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident, 2nd.</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>26 years</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 23</u> , 19 <u>47</u> to <u>Sept. 21</u> , 19 <u>80</u> that (I) (we) lost <u>July 8</u> , 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Robert Barthel M.D.</u>		22c. DATE SIGNED Sept. 21, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Barthel M.D.		22e. ADDRESS 2501 Rocks Rd., Forest Hill, Md. 21050	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-23-80	
23c. NAME OF CEMETERY OR CREMATORY Dublin UM		23d. LOCATION CITY OR TOWN COUNTY STATE Dublin Harford Maryland	
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main Street, Delta, Pa.		25a. DATE REC'D. BY REGISTRAR SEP 23 1980	
25b. REGISTRAR'S SIGNATURE <u>Robert Barthel</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 3 5 9 3

1. DECEASED-NAME (Type or print) <b>Albert Lee Rutherford</b>			2a. DATE OF DEATH Month <b>September</b> Day <b>29</b> Year <b>1980</b>			2b. HOUR <b>5:52</b> MIN <b>A</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>October 5, 1916</b>		6. AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford</b> Md.					
10. CITY OR TOWN OF DEATH <b>Jarrettsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3203 Rocks Chrome Hill</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Supervisor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Highways</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Harford Jarrettsville</b>			13c. CITY OR TOWN <b>Jarrettsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3203 Rocks Chrome Hill</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>Hiram</b> Last <b>Rutherford</b>			15. MOTHER'S MAIDEN NAME First <b>Bessie</b> Middle <b>May</b> Last <b>Cook</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-12-6729</b>			17. INFORMANT <b>Joseph P. Rutherford</b>			Address <b>same as above</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Small Cell Carcinoma of Lung metastatic to brain</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus, Juvenile Type</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I (this hospital) attended the deceased from <b>October 19, 1947</b> , to <b>Sept. 29, 1980</b> , that I ( <del>we</del> ) last saw the deceased alive on <b>Jan. 16/80</b> 19__, and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, I ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <b>Robert Barthel M.D.</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>Sept. 29/80</b>		
22d. PHYSICIAN'S NAME (Type) <b>Robert Barthel M.D.</b>			22e. ADDRESS <b>2501 Rocks Rd., Forest Hill, Md. 21050</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Oct. 1, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>			23d. LOCATION (City or Town) (County) (State) <b>Harford, Md.</b>			
24. FUNERAL DIRECTOR <b>M. Gladden Kurtz III</b>			ADDRESS <b>Jarrettsville, Md.</b>			25a. FILED BY REGISTRAR <b>0011</b>			25b. REGISTRAR'S SIGNATURE <b>1980</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 5 9 4

FOR  
1- STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Maude Nora SADLER			2a DATE OF DEATH MONTH DAY YEAR 9-16-80			2b HOUR 2 12 P.M.		
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 10 14 02		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD				
10 CITY OR TOWN OF DEATH Fallston	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN Cardiff		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Henry T. Cox		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah T. Gibbs		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				
16b SOCIAL SECURITY NO. 217-07-9653		17 INFORMANT ADDRESS E. Lloyd Sadler, Cardiff, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac &amp; Respiratory Arrest</u> 4169 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Cor Pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac arrhythmia, CHF</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>COPD severe pulmonary emphysema</u>	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22 I certify that (I) this hospital attended the deceased from <u>9/15/80</u> to <u>9/16/80</u> that (II) (we) (lost) saw the deceased alive on <u>9/15/80</u> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.								
22b SIGNATURE <u>Albert Sun, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Albert Sun, M.D.		22e ADDRESS 1800 Harford Rd, Fallston						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9-19-80		23c NAME OF CEMETERY OR CREMATORY Broad Creek Friends		23d LOCATION CITY OR TOWN COUNTY STATE Street, Harford Co., Md.		
24 FUNERAL DIRECTOR NAME John H. Harkins		ADDRESS 600 Main St. Delta, Pa.		25a RECEIVED BY REGISTRAR SEP 22 1980		25b REGISTRAR'S SIGNATURE Morty McQuady		

BP

(25)

CHIEF CLERK

NOTICE

0000 8 8 9 30

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Manouchehr Sarhaddi</b> (John)										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 9 YEAR 1980	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 2 DAY 24 YEAR 35	6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS	7. IF UNDER 24 HRS MONTHS DAYS HOURS MIN	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD		2b. HOUR 5:00A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iran (Tehran)	7b. CITIZEN OF WHAT COUNTRY? Iran		10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			
13a. STATE Md.		13b. COUNTY Harford	13c. CITY OR TOWN Fallston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2415 Derby Drive		12b. KIND OF BUSINESS OR INDUSTRY Bendix			
14. FATHER'S NAME FIRST MIDDLE LAST Not Available				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ehteram Sarhaddi				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 387-40-6462				17. INFORMANT Soraya Sarhaddi (daughter)				ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:00PM 9 14 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/parked auto impact			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 152 s. of Rt. 165, Fallston, Harford, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 9/15/80			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment				23b. DATE 9/19/1980				23c. NAME OF CEMETERY OR CREMATORY Harford Memorial			
24. FUNERAL DIRECTOR NAME E. Barnes Fleming				ADDRESS Benson, Maryland				23d. LOCATION CITY OR TOWN COUNTY STATE Aldino Harford Md.			
25a. DATE RECEIVED BY SEP 19 1980				25b. NAME OF REGISTRAR <i>Harry McBratney</i>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		3 0 2 3 5 9 6	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
Mary Lee Shook		ESTIMATED <input checked="" type="checkbox"/> 9 12 19 80	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
F	W	3 25 85	45 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Tennessee		USA	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Havre De Grace		126 Bloomsbury Ave. HDG	
13a. STATE		13b. COUNTY	
MD		Harford	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Emmet N M N Smith		Bessie N M N Dyson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	
NO		215-34-6063	
17. INFORMANT		17b. ADDRESS	
Linda Holderman		301 Northway	
Personal Papers		Havre de Grace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Cardio-respiratory Failure			
303- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			
(b) Alcoholism			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY	
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			
21f. LOCATION		CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Luis E. Renjel		M.D. Deputy	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Luis E. Renjel, M.D.		9-16-80	
ADDRESS		464 Alliance St. Havre De Grace, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		9-18-1980	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Belair Mem. Gardens		Belair Harford MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR	
PENNINGTON & SON		SEP 18 1980	
NAME		25b. REGISTRAR'S SIGNATURE	
Havre de Grace MD		[Signature]	





100% COTTON



256 18 1901

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												8023597	
1 - STATE REGISTRAR		CERTIFICATE OF DEATH										REG NO.	
1 DECEASED NAME (TYPE OR PRINT)		FIRSI		MIDDLE		LAST		2a DATE OF DEATH				2b HOUR	
Pearl S HAW Steinbock								9-27-80				2 30 M	
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)				7b MONTH DAY YEAR	
FEMALE		WHITE		2 - 1 - 95				85				MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH					
Timber Ridge, Va		U.S.A.						Harford				MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WEEK)		12b KIND OF BUSINESS OR INDUSTRY			
Bel Air		Bel Air Convalescent Center						XXXXXXXXXX		SALES REAL ESTATE			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS					
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21222 6525 Cleveland Ave.					
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME				16a ADDRESS					
David Edward Shaw				Nannie White									
16b WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16c SOCIAL SECURITY NO.				17 INFORMANT ADDRESS					
No				216-10-8898				FRANCES E. GWIN (DAUGHTER) SAME AS 13e					
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>DIABETES MELLITUS &amp; HT 1</u>												day	
2300 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
1500: Cerebral Infarction & Chronic Brain Injury													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED		21d INJURY OCCURRED							
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2									
		P.M. 19											
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION		CITY OR TOWN		COUNTY		STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET		STREET									
22a I certify that (I) this hospital attended the deceased from <u>9/16</u> 19 <u>80</u> to <u>9/27</u> 19 <u>80</u> that (I) (we) lost													
saw the deceased alive on <u>9/27</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) not view the body after death													
22b SIGNATURE				DEGREE				22c DATE SIGNED					
Hector Santos								9/27/80					
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS									
Hector Santos													
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		COUNTY		STATE			
BURIAL		9/30/1980		UNION CHAPEL CEMETERY		HOT SPRINGS				VIRGINIA			
24 FUNERAL DIRECTOR				25 DATE REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE					
WALTER BROOKS BRADLEY, INC., DUNDALK, MD. 21222				OCT 1 1980				Hector Santos					



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **8 0 2 3 5 9 8**

**1- FOR  
STATE  
REGISTRAR**

<b>1. DECEASED NAME</b> (TYPE OR PRINT)		FIRST <b>ALMON</b>		MIDDLE <b>(nmn)</b>		LAST <b>STROUPE</b>		<b>2a. DATE KNOWN OF DEATH</b> ESTI. <input checked="" type="checkbox"/> MONTH <b>9</b> DAY <b>29</b> YEAR <b>1980</b>		<b>2b. HOUR</b> <b>M</b>	
<b>3. SEX</b> <b>M</b>	<b>4. RACE</b> <b>Cauc</b>	<b>5. DATE OF BIRTH</b> MONTH <b>5</b> DAY <b>4</b> YEAR <b>2060</b>		<b>6. AGE (IN YEARS)</b> LAST BIRTHDAY <b>60</b> YRS.		<b>IF UNDER 1 YR</b> MONTHS <b>0</b> DAYS <b>0</b>		<b>IN UNDER 24 HRS</b> HOURS <b>0</b> MIN <b>0</b>		<b>2c. DATE PRONOUNCED DEAD</b> MONTH <b>19</b> DAY <b>19</b> YEAR <b>1980</b>	
<b>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)</b> <b>Arkansas</b>		<b>7b. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>8. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Harford</b> MD.					
<b>10. CITY OR TOWN OF DEATH</b> <b>Fallston</b>		<b>11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION</b> (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hospital</b>				<b>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)</b> <b>General Engr.</b>		<b>12b. KIND OF BUSINESS OR INDUSTRY</b> <b>US-govt.</b>			
<b>13a. STATE</b> <b>Md</b>		<b>13b. COUNTY</b> <b>Harford</b>		<b>13c. CITY OR TOWN</b> <b>Bel Air</b>		<b>13d. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>13e. STREET ADDRESS</b> <b>33 Idlewild Street</b>			
<b>14. FATHER'S NAME</b> FIRST <b>Almon</b> MIDDLE <b>--</b> LAST <b>Stroupe Sr.</b>						<b>15. MOTHER'S MAIDEN NAME</b> FIRST <b>Ruth</b> MIDDLE <b>--</b> LAST <b>Cobb</b>					
<b>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (YES, NO, OR UNKNOWN) <b>Yes</b>				<b>16b. SOCIAL SECURITY NO.</b> (IF YES, GIVE YEAR OR DATES) <b>WWII 561-36-9255</b>		<b>17. INFORMANT ADDRESS</b> <b>Mrs. Marian R. Stroupe, Bel Air, Md.</b>					

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>4140 Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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<b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1</b> <b>Cerebrovascular Arteriosclerotic Disease</b>					
<b>19a. DATE OF OPERATION</b>		<b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b>		<b>21b. TIME OF INJURY</b> HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		<b>21c. HOW INJURY OCCURRED</b> (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
<b>21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/></b>		<b>21e. PLACE OF INJURY</b> (AT HOME, STREET, FACTORY, FARM, ETC.)		<b>21f. LOCATION</b> STREET CITY OR TOWN COUNTY STATE	

<b>22a. I certify that I took charge of the remains described above, held on death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
<b>ACTUAL SIGNATURE</b> <b>Willard P. Amoss</b>		<b>M.D.</b> <b>Real Es</b>		<b>DATE SIGNED</b> <b>9/29/80</b>	
<b>EXAMINER'S NAME</b> (TYPE OR PRINT) <b>Willard P. Amoss</b>		<b>ADDRESS</b> <b>2404 Pleasantville Rd Fallston Md</b>			

<b>23a. BURIAL, CREMATION, REMOVAL</b> (SPECIFY) <b>Burial</b>		<b>23b. DATE</b> <b>Oct. 2, 1980</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bel Air Mem. Gardens</b>		<b>23d. LOCATION</b> CITY OR TOWN <b>Bel Air</b> COUNTY <b>Harford</b> STATE <b>Md.</b>	
<b>24. FUNERAL DIRECTOR</b> NAME <b>Howard K. McComas III, Abingdon, Md.</b> ADDRESS				<b>25a. DATE REC'D. BY REGISTRAR</b> <b>SEP 30 1980</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Henry K. Brady</b>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF OF POLICE. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 7, 8, AND 9 TO THE CHIEF OF POLICE. GIVE PAGES 10, 11, AND 12 TO THE CHIEF OF POLICE. GIVE PAGES 13, 14, AND 15 TO THE CHIEF OF POLICE. GIVE PAGES 16, 17, AND 18 TO THE CHIEF OF POLICE. GIVE PAGES 19, 20, AND 21 TO THE CHIEF OF POLICE. GIVE PAGES 22, 23, AND 24 TO THE CHIEF OF POLICE. GIVE PAGES 25, 26, AND 27 TO THE CHIEF OF POLICE. GIVE PAGES 28, 29, AND 30 TO THE CHIEF OF POLICE. GIVE PAGES 31, 32, AND 33 TO THE CHIEF OF POLICE. GIVE PAGES 34, 35, AND 36 TO THE CHIEF OF POLICE. GIVE PAGES 37, 38, AND 39 TO THE CHIEF OF POLICE. GIVE PAGES 40, 41, AND 42 TO THE CHIEF OF POLICE. GIVE PAGES 43, 44, AND 45 TO THE CHIEF OF POLICE. GIVE PAGES 46, 47, AND 48 TO THE CHIEF OF POLICE. GIVE PAGES 49, 50, AND 51 TO THE CHIEF OF POLICE. GIVE PAGES 52, 53, AND 54 TO THE CHIEF OF POLICE. GIVE PAGES 55, 56, AND 57 TO THE CHIEF OF POLICE. GIVE PAGES 58, 59, AND 60 TO THE CHIEF OF POLICE. GIVE PAGES 61, 62, AND 63 TO THE CHIEF OF POLICE. GIVE PAGES 64, 65, AND 66 TO THE CHIEF OF POLICE. GIVE PAGES 67, 68, AND 69 TO THE CHIEF OF POLICE. GIVE PAGES 70, 71, AND 72 TO THE CHIEF OF POLICE. GIVE PAGES 73, 74, AND 75 TO THE CHIEF OF POLICE. GIVE PAGES 76, 77, AND 78 TO THE CHIEF OF POLICE. GIVE PAGES 79, 80, AND 81 TO THE CHIEF OF POLICE. GIVE PAGES 82, 83, AND 84 TO THE CHIEF OF POLICE. GIVE PAGES 85, 86, AND 87 TO THE CHIEF OF POLICE. GIVE PAGES 88, 89, AND 90 TO THE CHIEF OF POLICE. GIVE PAGES 91, 92, AND 93 TO THE CHIEF OF POLICE. GIVE PAGES 94, 95, AND 96 TO THE CHIEF OF POLICE. GIVE PAGES 97, 98, AND 99 TO THE CHIEF OF POLICE. GIVE PAGES 100, 101, AND 102 TO THE CHIEF OF POLICE. GIVE PAGES 103, 104, AND 105 TO THE CHIEF OF POLICE. 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GIVE PAGES 646, 647, AND 648 TO THE CHIEF OF POLICE. GIVE PAGES 649, 650, AND 651 TO THE CHIEF OF POLICE. GIVE PAGES 652, 653, AND 654 TO THE CHIEF OF POLICE. GIVE PAGES 655, 656, AND 657 TO THE CHIEF OF POLICE. GIVE PAGES 658, 659, AND 660 TO THE CHIEF OF POLICE. GIVE PAGES 661, 662, AND 663 TO THE CHIEF OF POLICE. GIVE PAGES 664, 665, AND 666 TO THE CHIEF OF POLICE. GIVE PAGES 667, 668, AND 669 TO THE CHIEF OF POLICE. GIVE PAGES 670, 671, AND 672 TO THE CHIEF OF POLICE. GIVE PAGES 673, 674, AND 675 TO THE CHIEF OF POLICE. GIVE PAGES 676, 677, AND 678 TO THE CHIEF OF POLICE. GIVE PAGES 679, 680, AND 681 TO THE CHIEF OF POLICE. GIVE PAGES 682, 683, AND 684 TO THE CHIEF OF POLICE. GIVE PAGES 685, 686, AND 687 TO THE CHIEF OF POLICE. GIVE PAGES 688, 689, AND 690 TO THE CHIEF OF POLICE. GIVE PAGES 691, 692, AND 693 TO THE CHIEF OF POLICE. GIVE PAGES 694, 695, AND 696 TO THE CHIEF OF POLICE. GIVE PAGES 697, 698, AND 699 TO THE CHIEF OF POLICE. GIVE PAGES 700, 701, AND 702 TO THE CHIEF OF POLICE. GIVE PAGES 703, 704, AND 705 TO THE CHIEF OF POLICE. GIVE PAGES 706, 707, AND 708 TO THE CHIEF OF POLICE. GIVE PAGES 709, 710, AND 711 TO THE CHIEF OF POLICE. GIVE PAGES 712, 713, AND 714 TO THE CHIEF OF POLICE. GIVE PAGES 715, 716, AND 717 TO THE CHIEF OF POLICE. GIVE PAGES 718, 719, AND 720 TO THE CHIEF OF POLICE. GIVE PAGES 721, 722, AND 723 TO THE CHIEF OF POLICE. GIVE PAGES 724, 725, AND 726 TO THE CHIEF OF POLICE. GIVE PAGES 727, 728, AND 729 TO THE CHIEF OF POLICE. GIVE PAGES 730, 731, AND 732 TO THE CHIEF OF POLICE. GIVE PAGES 733, 734, AND 735 TO THE CHIEF OF POLICE. GIVE PAGES 736, 737, AND 738 TO THE CHIEF OF POLICE. GIVE PAGES 739, 740, AND 741 TO THE CHIEF OF POLICE. GIVE PAGES 742, 743, AND 744 TO THE CHIEF OF POLICE. GIVE PAGES 745, 746, AND 747 TO THE CHIEF OF POLICE. GIVE PAGES 748, 749, AND 750 TO THE CHIEF OF POLICE. GIVE PAGES 751, 752, AND 753 TO THE CHIEF OF POLICE. GIVE PAGES 754, 755, AND 756 TO THE CHIEF OF POLICE. GIVE PAGES 757, 758, AND 759 TO THE CHIEF OF POLICE. GIVE PAGES 760, 761, AND 762 TO THE CHIEF OF POLICE. GIVE PAGES 763, 764, AND 765 TO THE CHIEF OF POLICE. GIVE PAGES 766, 767, AND 768 TO THE CHIEF OF POLICE. GIVE PAGES 769, 770, AND 771 TO THE CHIEF OF POLICE. GIVE PAGES 772, 773, AND 774 TO THE CHIEF OF POLICE. GIVE PAGES 775, 776, AND 777 TO THE CHIEF OF POLICE. GIVE PAGES 778, 779, AND 780 TO THE CHIEF OF POLICE. GIVE PAGES 781, 782, AND 783 TO THE CHIEF OF POLICE. GIVE PAGES 784, 785, AND 786 TO THE CHIEF OF POLICE. GIVE PAGES 787, 788, AND 789 TO THE CHIEF OF POLICE. GIVE PAGES 790, 791, AND 792 TO THE CHIEF OF POLICE. GIVE PAGES 793, 794, AND 795 TO THE CHIEF OF POLICE. GIVE PAGES 796, 797, AND 798 TO THE CHIEF OF POLICE. GIVE PAGES 799, 800, AND 801 TO THE CHIEF OF POLICE. GIVE PAGES 802, 803, AND 804 TO THE CHIEF OF POLICE. GIVE PAGES 805, 806, AND 807 TO THE CHIEF OF POLICE. GIVE PAGES 808, 809, AND 810 TO THE CHIEF OF POLICE. GIVE PAGES 811, 812, AND 813 TO THE CHIEF OF POLICE. GIVE PAGES 814, 815, AND 816 TO THE CHIEF OF POLICE. GIVE PAGES 817, 818, AND 819 TO THE CHIEF OF POLICE. GIVE PAGES 820, 821, AND 822 TO THE CHIEF OF POLICE. GIVE PAGES 823, 824, AND 825 TO THE CHIEF OF POLICE. GIVE PAGES 826, 827, AND 828 TO THE CHIEF OF POLICE. GIVE PAGES 829, 830, AND 831 TO THE CHIEF OF POLICE. GIVE PAGES 832, 833, AND 834 TO THE CHIEF OF POLICE. GIVE PAGES 835, 836, AND 837 TO THE CHIEF OF POLICE. GIVE PAGES 838, 839, AND 840 TO THE CHIEF OF POLICE. GIVE PAGES 841, 842, AND 843 TO THE CHIEF OF POLICE. GIVE PAGES 844, 845, AND 846 TO THE CHIEF OF POLICE. GIVE PAGES 847, 848, AND 849 TO THE CHIEF OF POLICE. GIVE PAGES 850, 851, AND 852 TO THE CHIEF OF POLICE. GIVE PAGES 853, 854, AND 855 TO THE CHIEF OF POLICE. GIVE PAGES 856, 857, AND 858 TO THE CHIEF OF POLICE. GIVE PAGES 859, 860, AND 861 TO THE CHIEF OF POLICE. GIVE PAGES 862, 863, AND 864 TO THE CHIEF OF POLICE. GIVE PAGES 865, 866, AND 867 TO THE CHIEF OF POLICE. GIVE PAGES 868, 869, AND 870 TO THE CHIEF OF POLICE. GIVE PAGES 871, 872, AND 873 TO THE CHIEF OF POLICE. GIVE PAGES 874, 875, AND 876 TO THE CHIEF OF POLICE. GIVE PAGES 877, 878, AND 879 TO THE CHIEF OF POLICE. GIVE PAGES 880, 881, AND 882 TO THE CHIEF OF POLICE. GIVE PAGES 883, 884, AND 885 TO THE CHIEF OF POLICE. GIVE PAGES 886, 887, AND 888 TO THE CHIEF OF POLICE. GIVE PAGES 889, 890, AND 891 TO THE CHIEF OF POLICE. GIVE PAGES 892, 893, AND 894 TO THE CHIEF OF POLICE. GIVE PAGES 895, 896, AND 897 TO THE CHIEF OF POLICE. GIVE PAGES 898, 899, AND 900 TO THE CHIEF OF POLICE. GIVE PAGES 901, 902, AND 903 TO THE CHIEF OF POLICE. GIVE PAGES 904, 905, AND 906 TO THE CHIEF OF POLICE. GIVE PAGES 907, 908, AND 909 TO THE CHIEF OF POLICE. GIVE PAGES 910, 911, AND 912 TO THE CHIEF OF POLICE. GIVE PAGES 913, 914, AND 915 TO THE CHIEF OF POLICE. GIVE PAGES 916, 917, AND 918 TO THE CHIEF OF POLICE. GIVE PAGES 919, 920, AND 921 TO THE CHIEF OF POLICE. GIVE PAGES 922, 923, AND 924 TO THE CHIEF OF POLICE. GIVE PAGES 925, 926, AND 927 TO THE CHIEF OF POLICE. GIVE PAGES 928, 929, AND 930 TO THE CHIEF OF POLICE. GIVE PAGES 931, 932, AND 933 TO THE CHIEF OF POLICE. GIVE PAGES 934, 935, AND 936 TO THE CHIEF OF POLICE. GIVE PAGES 937, 938, AND 939 TO THE CHIEF OF POLICE. GIVE PAGES 940, 941, AND 942 TO THE CHIEF OF POLICE. GIVE PAGES 943, 944, AND 945 TO THE CHIEF OF POLICE. GIVE PAGES 946, 947, AND 948 TO THE CHIEF OF POLICE. GIVE PAGES 949, 950, AND 951 TO THE CHIEF OF POLICE. GIVE PAGES 952, 953, AND 954 TO THE CHIEF OF POLICE. GIVE PAGES 955, 956, AND 957 TO THE CHIEF OF POLICE. GIVE PAGES 958, 959, AND 960 TO THE CHIEF OF POLICE. GIVE PAGES 961, 962, AND 963 TO THE CHIEF OF POLICE. GIVE PAGES 964, 965, AND 966 TO THE CHIEF OF POLICE. GIVE PAGES 967, 968, AND 969 TO THE CHIEF OF POLICE. 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GIVE PAGES 1024, 1025,



RECEIVED  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS MERRILL STUART</b>		2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 9-14-80		2b. HOUR 8 <sup>00</sup> PM
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>21</b> YEAR <b>1964</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>64</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b> MD.	
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HARFORD Memorial Hosp</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Bank Clerk</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. CITY <b>BALTIMORE</b>	13c. CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>7-5 Teacher CT. 21234</b>
14. FATHER'S NAME FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>Stuart</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b> MIDDLE <b>Belle</b> LAST <b>Waggoner</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>216-10-1793</b>	17. INFORMANT <b>Mrs Janet M Stuart</b> <b>HOSPITAL 411 HAMM</b> Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Heart Disease</b> 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>ASCUD</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Luis E Renjel</b>		TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER		DATE SIGNED <b>9-15-80</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>LUIS E. RENJEL</b>		ADDRESS <b>464 Alliance St. Havre de Grace 21234</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>9/17/80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	23d. LOCATION CITY OR TOWN <b>Baltimore, Maryland</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Leonard JRuck Inc. Baltimore, Maryland</b> ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>SEP 16 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 2 3 6 0 0		REG NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ELLAMAE M M Tarbert</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Sept 9 1980</b>		2b. HOUR <b>9:40 P.M.</b>	
3 SEX <b>Female</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 22 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b> MD	
10. CITY OR TOWN OF DEATH <b>Haure de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Aberdeen</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert B. Berry</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Absher</b>		13e. STREET ADDRESS <b>74 Norman Ave</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-143647</b>		17. INFORMANT ADDRESS <b>Paul E. Tarbert, 74 Norman Ave., Aberdeen, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> 5770 DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Pancreatic acute necrotic</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Perforated gastric ulcer</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION <b>8/22/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED. <b>Acute pancreatitis</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 14</b> 19 <b>80</b> to <b>Sept 9</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Sept 9</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Wm K Brendle</b> M.D. DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>7/10/80</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm K Brendle</b>	
22e. ADDRESS <b>Lewis ST Haure de Grace</b>				22f. ADDRESS <b>Lewis ST Haure de Grace</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>13 Sep. 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bakers Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aberdeen Harford Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Tarring Funeral Home, P.A., Aberdeen, Md. 21001</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 6 0 1

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Katherine B. Taylor			2a. DATE OF DEATH MONTH DAY YEAR Sept 9 1980			2b. HOUR 6 <sup>26</sup> p.m.			
3. SEX Female		4. RACE Black Negro		5. DATE OF BIRTH MONTH DAY YEAR 5 sept. 7, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Un. of Md.	
13a. STATE Md.		13b. COUNTY Port Deposit		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 36	
14. FATHER'S NAME Charles Banks				15. MOTHER'S MAIDEN NAME Sarah Herod					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-16-4867		17. INFORMANT Katherine A. Taylor, P.O. Box 36, Port Deposit, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) ASD Conditions, if any, which gave rise to immediate cause, (b), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN (a) AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/11 so to 9/17 so		21g. I certify that (I) (this hospital) attended the deceased from 9/17 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (did not) view the body after death.			
22a. SIGNATURE Joun D Yun		22b. PHYSICIAN'S NAME (TYPE OR PRINT) Joun D Yun		22c. ADDRESS Harre de Grace, Md		22d. DATE SIGNED 9/21/80		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 11, 1980		23c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit Cecil, Maryland			
24. FUNERAL DIRECTOR NAME Lee A. Patterson & Son, Perryville, Maryland		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 10 1980		25b. REGISTRAR'S SIGNATURE T. K. Brady			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY OTHER NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN THIS COPY FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VS-15 ME (5))  
15M-7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 2 3 6 0 2

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>STANLEY ISABORE TAYLOR</b>		2a. DATE KNOWN OF DEATH ESTIMATED <b>9 24 19 80</b>		2b. HOUR <b>6 20 PM</b>	
3. SEX <b>M</b>	4. RACE <b>N</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 26, 1923</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>56 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FALLSTON GEN HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baggageman</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>Edgewood</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Matthew Taylor</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eula Jane Hounsby</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE NUMBER) <b>215-16-6108</b>		17. INFORMANT ADDRESS <b>Mrs. Eula J. Hill, Edgewood, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Perforated viscus, shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Diabetes Mellitus Dehydration</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Willard R Amoss</b>		TITLE (SPECIFY) <b>Asst Dep</b>		DATE SIGNED <b>9/24/80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Willard R Amoss</b>		ADDRESS <b>2404 Pleasantville Rd, Fallston Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 29, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>	
24. FUNERAL DIRECTOR NAME <b>Howard K. MComas III</b>		ADDRESS <b>Abingdon, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1980</b>	
		25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>			

MEDICAL CERTIFICATION

(M)



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8023603					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Troy Lee Todd</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 24 1980</b>		2b. HOUR M <b>8:42 a.m.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 15, 1962</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>18</b>		IF UNDER 1 YR MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 24 1980</b>					
7a. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b> MD					
10. CITY OR TOWN OF DEATH <b>Bel Air</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. #136, N. of Hookers Mill Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>					
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Joppa</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2517 Mountain Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ott Lee Todd, Jr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hazel Ann Smith</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>217-86-5121</b>		17. INFORMANT ADDRESS <b>Ott Lee Todd, Jr., Joppa, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Head and Neck Injuries</b> IMMEDIATE CAUSE (a) <b>Head and Neck Injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Head and Neck Injuries</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7:15 a.m. 9 24 1980</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>pedestrian struck by hit &amp; run vehicle</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. #136, N. of Hookers Mill Rd., Harford Co., Maryland</b>							
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>9-24-80</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Sept. 27, 1980</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Mem. Gardens, Middle River-Balto-Md.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1980</b>				25b. REGISTRAR'S SIGNATURE <b>Anthony M. Kelly</b>							





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*Handwritten signature*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 6 0 4

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Dorothy May Ward			2a DATE OF DEATH MONTH DAY YEAR September 19 1980			2b HOUR 4 <sup>35</sup> AM			
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR 9 9 1926		6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS		7 UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD			
10 CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Janitorial Service, Bd. Education			12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md			13b COUNTY Harford		13c CITY OR TOWN Aberdeen		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST McCarroll Ward			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Arvin			13e STREET ADDRESS 519 2nd. Street, Aberdeen, Md.			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 230-22-8999		17 INFORMANT Aberdeen, Md. 21001 Margaret Christy, 119 W. Bel Air, Ave.				
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas</u> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>with metastasis to the liver</u> (c) <u>intestines</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>Sept. 19</u> 19 <u>80</u> , to <u>Sept. 19</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Sept. 19</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Vicente R. Carag Jr						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/19/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) V. R. CARAG JR						22e ADDRESS 304 LEWIS ST. HDE-			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial			23b DATE 9/21/1980		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE Greene, Nottoway Co. Va.		
24 FUNERAL DIRECTOR NAME Tarring Funeral Home, PA. Aberdeen, Md. 21001						25a DATE REC'D. BY REGISTRAR SEP 26 1980		25b REGISTRAR'S SIGNATURE P. H. H. H.	

BP



12-1-1950

USA

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219 2nd Street, Aberdeen, Md.

Aberdeen

12-1-1950

12-1-1950

Ward

Annie

Aberdeen, Md. 2101

237-2-1950 12-1-1950 12-1-1950

237-2-1950 12-1-1950 12-1-1950

237-2-1950 12-1-1950 12-1-1950

237-2-1950 12-1-1950 12-1-1950

237-2-1950 12-1-1950 12-1-1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

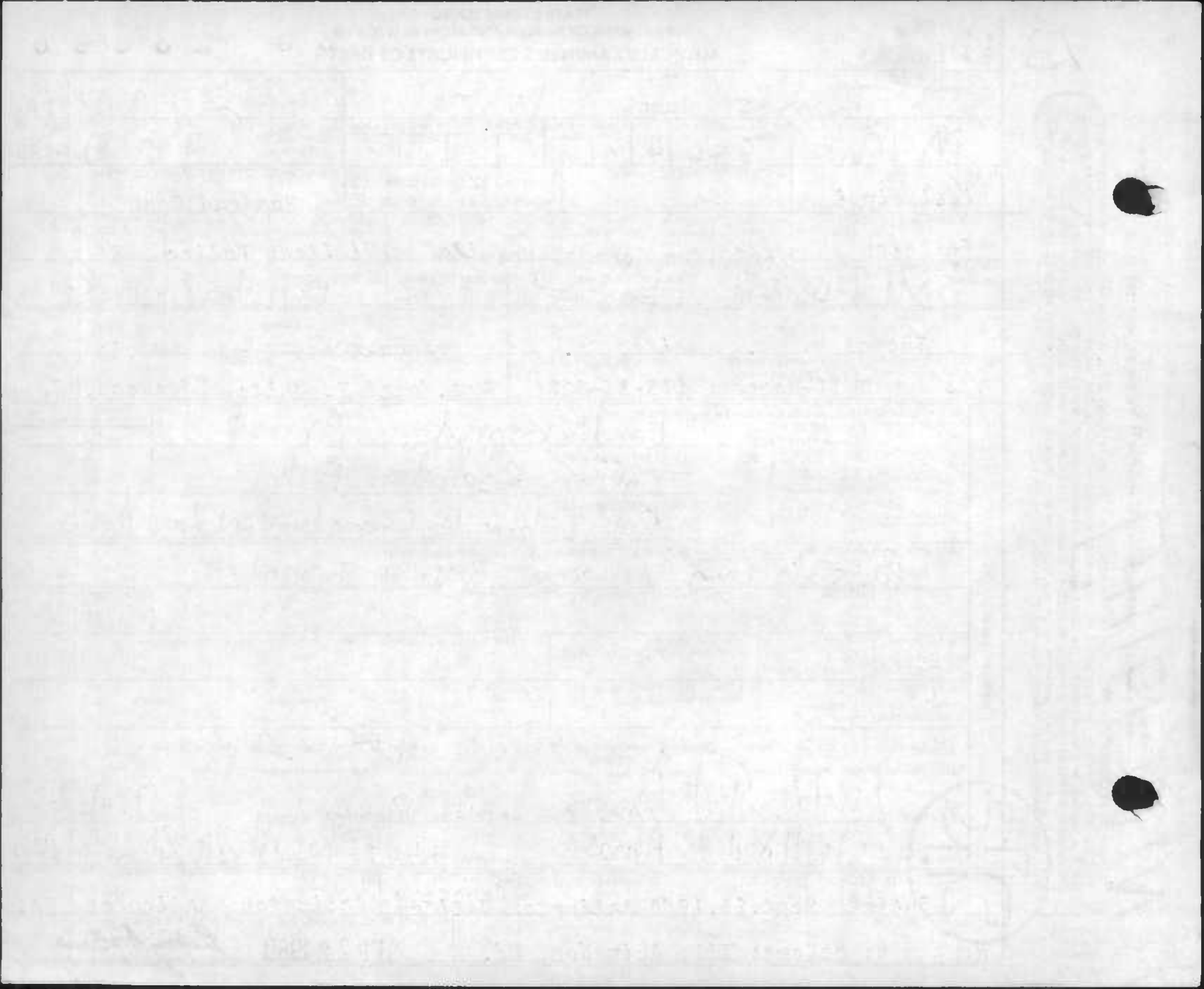
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 3 6 0 5			
1 - FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nellie ROSENA Way				2a DATE OF DEATH MONTH DAY YEAR Sept 7 1980			
3 SEX Female				2b HOUR 7 <sup>50</sup> PM			
4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 10 22 1899		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD	
10 CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DET. INSPECTOR		12b KIND OF BUSINESS OR INDUSTRY EDGEWOOD ARSENAL	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b COUNTY Harford		13c CITY OR TOWN Havre de Grace		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST HOWARD JOSEPH Tudor		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ROONEY		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 220-20-7021	
17 INFORMANT ADDRESS ARTHUR H. WAY 660 GREEN ST. HAVRE DE GRACE, MD. 21078							
18 CAUSE OF DEATH (Enter only one cause, but the medical examiner may list more than one.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 436- DCA, Massine DUE TO OR AS A CONSEQUENCE OF Q. H. ASUO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 9/5 80 to 9/6 80, that (I) (we) lost saw the deceased alive on 9/5 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				22b SIGNATURE Blair Jones			
22c PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. YUN				22d ADDRESS Havre de Grace, Md		22e DATE SIGNED 9/7/80	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE SEPT. 11 1980		23c NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d LOCATION CITY OR TOWN COUNTY STATE HAVRE DE GRACE HARFORD MD.	
24 FUNERAL DIRECTOR NAME R. Madison Mitchell				24b ADDRESS HAVRE DE GRACE, MD.		25a DATE RECEIVED BY REGISTRAR SEP 11 1980	
				25b REGISTRAR'S SIGNATURE notary			

20271001  
 20271001  
 20271001

HOWARD	JOSEPH	JOHN	MARY	—	ROONEY
no	—	100-2000	FRANK H. WAY	and others et al	MAYRE DE BRACE, M.D. 1018

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23606	
1- STATE REGISTRAR										7a. DATE KNOWN OF DEATH ESTIMATED	
1 DECEASED NAME (TYPE OR PRINT) <u>Thomas (nmn) White</u>										7b. HOUR <u>9:28 AM</u>	
3 SEX <u>M</u>		4 RACE <u>Cauc</u>		5 DATE OF BIRTH MONTH <u>6</u> DAY <u>26</u> YEAR <u>1966</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>66</u> YRS.		7c. DATE PRONOUNCED DEAD MONTH <u>9</u> DAY <u>19</u> YEAR <u>1980</u>		7d. HOUR <u>4:59 PM</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Mississippi</u>				7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford County</u>				10 CITY OR TOWN OF DEATH <u>Fallston</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Fallston General Hospital</u>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Military Police</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>USA</u>				13a. STATE <u>Md</u>			
13b. COUNTY <u>Harford</u>				13c. CITY OR TOWN <u>Edgewood</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS <u>1811 Van Bibber Rd.</u>				14. FATHER'S NAME FIRST <u>Thomas</u> MIDDLE <u>W.</u> LAST <u>White, Sr.</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Margarette</u> MIDDLE <u>-</u> LAST <u>Davis</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Yes</u>				16b. SOCIAL SECURITY NO. <u>WWII-Korea 215-38-8878</u>				17. INFORMANT ADDRESS <u>Mrs. Hazel T. White, Edgewood, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cor Pulmonale, Granulomatous Lung Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Possible Lung Carcinoma, Possible Tuberculosis</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <u>Willard P Amos</u>				TITLE (SPECIFY) <u>Asst Dir</u>				MEDICAL EXAMINER DATE SIGNED <u>9/19/80</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>Willard P Amos</u>				ADDRESS <u>2404 Pleasantville Rd Fallston Md</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>Sept. 23, 1980</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>			
23d. LOCATION CITY OR TOWN <u>Arlington</u>				COUNTY <u>Arlington</u>				STATE <u>Va.</u>			
24. FUNERAL DIRECTOR NAME <u>Howard K. McComas III</u>				ADDRESS <u>Abingdon, Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>SEP 22 1980</u>			
								25b. REGISTRAR'S SIGNATURE <u>Patricia McComas</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8023607	
1 - FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) ELIZABETH RINKER YEANY						2a DATE OF DEATH MONTH DAY YEAR 9/20/80		2b HOUR 11:55 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 26 11		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD					
10 CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.O. Box 177				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b KIND OF BUSINESS OR INDUSTRY Music			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN Fallston		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS P.O. Box 177, 21047			
14 FATHER'S NAME FIRST MIDDLE LAST Rev. Ralph Yeany				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Rinker							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b SOCIAL SECURITY NO. 193.22.6434		17. INFORMANT ADDRESS Elizabeth Jane Miles--Same as 13e					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BOWEL Obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 1 year			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION 7/8/80		19b CONDITION FOR WHICH OPERATION WAS PERFORMED carcinoma of colon				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>9/16</u> 19 <u>80</u> , to <u>9/20</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>9/16</u> 19 <u>80</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Phyllis K. Pullen				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/20/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Phyllis K. Pullen MD				22e ADDRESS 2807 Jerusalem Rd, Kingville, Md 21087							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 9/22/1980		23c NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24 FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc., Balto., Md. 21222				25a DATE REC'D. BY REGISTRAR SEP 25 1980		25b REGISTRAR'S SIGNATURE [Signature]					



1 DECEASED NAME (TYPE OR PRINT)		FIRST NORA		MIDDLE M.		LAST ZADROGA		2a DATE OF DEATH		MONTH 8	YEAR 31	2b HOUR 4 <sup>05</sup> P.M.
3 SEX F		4 RACE W		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		# UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford Co.		MONTHS		DAYS		
10 CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE MD.		13b COUNTY HARFORD		13c CITY OR TOWN BEAIR		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 617 S. SHAMROCK RD		
14 FATHER'S NAME FIRST GEORGE MIDDLE NILES LAST		15 MOTHER'S MAIDEN NAME FIRST MARY MIDDLE LENNON LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 212 184150		17 INFORMANT CATHERINE DOROB		ADDRESS SAME		
18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b, and 1c. PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE 1a) 410+ Acute Myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease. DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomegaly - Left B.B. Block		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Diabetes mellitus, UTI, CVA (left infarct)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from 8-12-1980 to 8-31-1980, that (I) (we) lost saw the deceased alive on 8-31-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE D. L. Pirovolidis		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 8/31/80				
22d PHYSICIAN'S NAME (TYPE OR PRINT) D. L. Pirovolidis		22e ADDRESS 1716 HARFORD Rd FALLSTON, Md. 210										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 9/4/1980		23c NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		23d LOCATION Baltimore		COUNTY MD		STATE		
24 FUNERAL DIRECTOR NAME RAYMOND H. KACZOROWSKI		ADDRESS 2525 FEET ST		25a DATE REC'D. BY REGISTRAR SEP 5 1980		25b REGISTRAR'S SIGNATURE P. J. K. K. K.						

U.S. GEOLOGICAL SURVEY  
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